Supreme Court, U.S.
FILED
07-895 JAN 2 - 2008
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No. ____

In The
Supreme Court of the United States

WALTER RICHARD HOUSE JR.,
Petitioner,

v.

AMERICAN UNITED LIFE INSURANCE COMPANY,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Two questions are presented:

1. In 2004, this Court held that an owner of a business *may* qualify as a participant in an employee benefit plan covered by ERISA where the plan covered both employees and the owner. *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 124 S.Ct. 1330, 158 L.Ed.2d 40 (2004). But the Court did not answer – and the circuits now disagree on – whether an owner of a business *must* qualify as a participant in an employee benefit plan covered by ERISA whenever both the owner and his employees participate in separate plans that differ in terms of coverage, benefits, and method of payment. Is an owner's benefit plan necessarily covered by ERISA merely because both he and his employees participate in benefit plans, as the Fifth Circuit held, or is an owner's benefit plan not covered by ERISA when it is demonstrably distinct from his employees' plan, as the Ninth and Eleventh Circuits have held?

2. After holding that ERISA applies, the Fifth Circuit panel turned its attention to the critical question of the law applicable to the case. Does applying federal common law when ERISA's Insurance Saving Clause requires the application of Louisiana insurance regulatory law judicially overrule the Saving Clause in direct conflict with the Rules of Decision Act, the Erie Doctrine, principles of comity and federalism, and the deference shown by other Federal Circuits to the will of Congress?

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PETITION FOR A WRIT OF CERTIORARI

Walter Richard House, Jr. respectfully petitions for a writ of certiorari to review the opinion of the U.S. Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

App. A, 1a–41a – Fifth Circuit's opinion dated September 4, 2007, officially reported at 499 F.3d 443.

App. B, 42a–44a – District Court's judgment dated January 20, 2006.

App. C, 45a–101a – District Court's third opinion dated April 20, 2004, unofficially reported at 2004 WL 856671.

App. D, 102a–153a – District Court's first opinion dated December 3, 2002, unofficially reported at 2002 WL 31729483.

App. E, 154a–156a – Fifth Circuit's Denial of Rehearing dated October 4, 2007, officially reported at 499 F.3d 443, 463.

JURISDICTION

The judgment of the U.S. Court of Appeals for the Fifth Circuit sought to be reviewed was entered on September 4, 2007, and rehearing was denied on October 4, 2007. This petition is timely under 28 U.S.C. § 2101(c) and Supreme Court Rule 13.3 because it is being filed within 90 days of the denial of rehearing. This Court has jurisdiction to review the

judgment of the U.S. Court of Appeals for the Fifth Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions involved are 28 U.S.C. § 1652, the Rules of Decision Act; 29 U.S.C. § 1144, the Insurance Saving Clause of the Employee Retirement Income Security Act of 1974; La. Revised Statute 22:230, Disability Loss of Income Policies; La. Revised Statute 22:215, Group Health and Accident Insurance; La. Revised Statute, 22:213, Individual Health and Accident Insurance; and 29 C.F.R. § 2510.3-3, Department of Labor regulations clarifying definition of "employee benefit plan." The relevant statutory provisions are reproduced at App. F, 157a-162a.

STATEMENT OF THE CASE

The claim of Walter Richard House, Jr. ("House"), the founding partner of a New Orleans law firm, arises out of a disability loss of income policy issued in Louisiana by American United Life Insurance Company ("AUL"). House engaged in a distinguished 25-year career as a trial lawyer prior to his disability, spending over 95% of his time on litigation and litigation-related matters. App. 2a, 86a-93a, 105a, 109a. He honed his litigation skills in this demanding, intense, stressful, and all-consuming specialty in the federal and state courts throughout the country and in

arbitration proceedings around the globe.[1] App. 90a-97a, 109a.

Suddenly at age 49, House was stricken with a heart attack, and one year later, after failing a treadmill stress test, a cardiovascular surgeon performed bypass surgery. App. 4a, 105a-106a. After surgery, House's cardiologist told him that the level of stress he encountered in his practice as a trial attorney significantly contributed to his acute myocardial infarction on October 9, 1999, and his quadruple coronary artery bypass surgery on October 4, 2000. The cardiologist warned House that under no circumstances should he return to his practice as a trial attorney. The most sobering advice from the cardiologist was that returning to the stress of trial work could cause severe medical repercussions, including death. App. 73a–96a.

Acting on his physician's admonitions, House gave up his trial practice, transferred all litigation matters, and withdrew from the law firm he had established. App. 2a, 110a-111a. After leaving his firm, House opened a solo "office" practice for a few months. App. 89a, 98a-99a. In October of 2001, he was hired by the State of Louisiana as Executive Counsel for the Department of Economic Development, a post that afforded him a substantially reduced annual income.

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[1] An AUL representative explained,"trial work is not a sedentary occupation and cannot standardly be done in a 40[hour] week." Similarly, an AUL adjuster noted that House's "time records showed that he worked 12-14 hour days each time that he went to trial." App. 96a.

App. 4a, 111a. As the trial judge found, House chose to "heed the proscription of his treating cardiologist placing his lucrative but overly stressful (and thus, life threatening) pre-disability occupation as a trial attorney off limits." App. 136a.

House was insured under a long term disability policy ("Policy"). No employees of the law firm were eligible to be insured under his Policy, it expressly being limited to "Full-Time Partners." App. 163a-164a. House, like his two partners, personally paid 100% of his premiums with after-tax dollars while the firm paid 100% of the policy premiums for the non-partner employees. App. 136a-138a, 169a. Employees were provided with less generous monetary benefits and, as to non-attorney employees, a less generous definition of total disability compared to the partners. App. 108a, 169-170a.

In November of 2000, House applied to AUL for disability benefits under this policy. App. 4a. House's cardiologist advised AUL of House's total and permanent disability from practicing as a trial attorney. App. 72a-75a, 128a. Although AUL has refused to accept this assessment of disability, "it has never . . . provided a countervailing medical opinion or produced other contradictory medical evidence." App. 76a.

AUL took almost a full year to inform House, on November 21, 2001, that it did not consider House to be Totally Disabled under the Policy, apparently deciding to go with "*management's* recommendation" to deny the claim "rather than pursuing an echocardiogram and/or an independent opinion from

another cardiologist." App. 83a, *emphasis in original*. According to AUL, "You appear to be capable of performing the sedentary occupation of an Attorney as it is normally performed in the national economy." AUL failed even to address the question of partial disability. App. 5a, 98a, 118a, 123a, 129a. Within three and a half months of the denial of benefits to House, his former law firm cancelled all of its insurance agreements with AUL. App. 22a.

Having exhausted his attempts to obtain benefits under his policy, House filed a diversity action in the United States District Court for the Eastern District of Louisiana. The district court meticulously documented AUL's bad faith in the handling of House's claim (App. 72a–100a, 127a-136a), terming AUL's reason for denying coverage "enigmatic." App. 87a. It concluded that AUL "abandoned its efforts to reasonably investigate" House's claims rather than "obtaining the additional objective medical evidence and an independent medical examination that it originally asserted was necessary to a proper evaluation of [the] claim." App. 100a. Finding that House was totally disabled under Louisiana law and that ERISA did not govern and thereby preempt the award of penalties, the district court awarded House substantial total disability benefits, as well as penalties and attorneys fees. App. 42a-44a, 134a.

A divided panel of the Fifth Circuit ("Majority") reversed, holding: (1) ERISA applies, having the effect of preempting the award of penalties under state law (App. 7a-17a); (2) House is partially disabled rather than totally disabled, finding "the district court's distinction between 'trial lawyer' and 'lawyer' too fine

under a *common sense* interpretation of 'regular occupation;'" (App. 19a, *emphasis supplied*) and (3) partial disability benefits terminated in February 2002 at the time House's former firm terminated its policies with AUL (App. 22a–24a). The Majority leaves House with an award of five months of partial disability benefits, less than $40,000, not including interest and attorneys fees.

Circuit Judge Dennis dissented (App. 25a–41a, 156a), providing this summation:

> Because the majority opinion (1) *disregards* the holding in *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986) to find that the insurance policy is governed by ERISA and (2) *ignores* the provisions of Louisiana Revised Statute section 22:230 and Louisiana jurisprudence on total disability policy definitions to conclude that Walter House does not qualify as totally disabled under the policy language, I respectfully dissent. App. 25a, *emphasis supplied*.

House's petitions for rehearing and rehearing *en banc* were both denied. App. 154a–156a.

REASONS FOR GRANTING THE PETITION

This petition for writ of certiorari to review the Fifth Circuit decision presents two questions, both causing division and confusion among the circuits and being *res nova* in this Court, and both affecting the rights of millions of plan participants and insurance policyholders. The first question is integral to the

compass of ERISA, and the second is important to a correct determination of whether federal common law or state law applies when a state law falls within the ambit of ERISA's Insurance Saving Clause.

First, on the question of *whether a partner's benefit plan is covered by ERISA when it is demonstrably distinct from his firm's separate plan for employees*, there is substantial disagreement between the Fifth Circuit and at least two other Federal Circuits, especially on the interpretation of the Federal Regulations discussed by this Court in *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 124 S.Ct. 1330, 158 L.Ed.2d 40 (2004). The Fifth Circuit, contrary to the Regulations reflecting the determination of the Secretary of Labor, and conflicting with the findings of the Ninth and Eleventh Circuits, misconstrues *Yates* and holds that a disability policy issued by an insurer to an owner of a business, here a partner, and paid for by him with after-tax dollars *must* be covered by ERISA even though the owner's policy is substantially different from the disability policies issued to employees and paid for by the business.

The broad purposes of ERISA are fulfilled through the statutory protection afforded employees rather than by forcing owners to be included, even though their plans have separate provisions and are paid for by them, individually. The Regulation presently in effect, disregarded by the Majority, recognizes this distinction, and does so in a manner consistent with *Yates*.

Second, this case presents the Court with an opportunity to address the fundamental question of *whether federal common law, as held by the Fifth Circuit, or Louisiana insurance regulatory law, as mandated by Congress, governs House's disability claim under ERISA's Insurance Saving Clause, the Rules of Decision Act, and Erie Doctrine.* It is hornbook law that applying federal common law rather than state law in a diversity action would violate the Rules of Decision Act, the Erie Doctrine and the principles of comity and federalism. Unless the Congress or the Constitution require otherwise, the Rules of Decision Act mandates application of relevant state law, even if the basis for jurisdiction is a federal question. "It frequently is said that the [Erie Doctrine] applies only in diversity of citizenship cases; this statement simply is wrong. The *Erie* case and the Supreme Court decisions following it apply in federal question cases as well." C. Wright, A. Miller & E. Cooper, *Federal Practice & Procedure* § 4520 (2007).

ERISA *requires* that state insurance regulatory law be applied to a fully insured plan where, as here, the state law is saved from preemption by the Saving Clause, thereby preserving the traditional role of the state in regulating insurance. *FMC Corp. v. Holliday*, 498 U.S. 52, 62, 111 S.Ct. 403, 410, 112 L.Ed.2d 356 (1990). State insurance regulatory law applies in its fullest *Erie* measure, whether or not ERISA also governs.[2] App. 115a-136a.

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[2] The Saving Clause "leaves room for complementary or dual federal and state regulation." *John Hancock Mut. Life Ins. Co. v.*

The Majority decision not only disregards 75 years of Louisiana decisional and statutory precedence, but effectively overrules, at least within the Fifth Circuit, the legislative will of Congress expressed in the Saving Clause. To protect such insurance regulatory law under ERISA, Congress established a boundary, the Saving Clause, prohibiting federal courts from impinging upon state regulatory insurance laws falling within that boundary: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ." 29 U.S.C. § 1144. This boundary is reinforced by the Constitution, as interpreted by *Erie* and its progeny, by Congress, through the Rules of Decision Act, and, in our case, by AUL itself, through the express language of its policy. Here, in contrast with principles long established by Congress and the Federal Court System, the Fifth Circuit crossed that boundary and, in so doing, deprived House of fundamental rights protected by Louisiana insurance regulatory law.

I. IS A PARTNER'S BENEFIT PLAN COVERED BY ERISA WHEN IT IS DEMONSTRABLY DISTINCT FROM HIS FIRM'S SEPARATE PLAN FOR EMPLOYEES?

In *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 124 S.Ct. 1330, 158 L.Ed.2d 40 (2004), this Court held that a working owner "*may*" qualify as an ERISA participant in the

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Harris Trust & Sav. Bank, 510 U.S. 86, 98, 114 S.Ct. 517, 525, 126 L.Ed.2d 524 (1993).

pension and profit sharing plans of his business as long as at least one employee other than the owner or the owner's spouse was a plan participant. *Yates*, 541 U.S. at 6, 8, 124 S.Ct. at 1335-1336. Using *Yates* as its predicate, the court below, contrary to applicable regulations and its own long-standing precedent, held that owners *must* be covered by ERISA, thus creating a conflict between the Fifth Circuit and at least two other Circuit Courts of Appeals in the interpretation of ERISA and its regulations.

A. The Majority opinion conflicts with applicable regulations promulgated by the Department of Labor.

Where the statute fails to provide specifics of interpretation, ERISA authorizes the Secretary of Labor to prescribe such regulations as he deems necessary (29 U.S.C. § 1135). The applicable regulation states without equivocation that the "term 'employee benefit plan' shall not include any plan . . . under which no employees are participants covered by the plan." 29 C.F.R. § 2510.3-3(b). The regulations clarify the definition of employee as such term is used in relation to partners: "A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership." 29 C.F.R. § 2510.3-3(c)(2). These regulations leave no doubt that a plan without an employee is not governed by ERISA. App. 161a-162a.

Over twenty years ago the Fifth Circuit, in *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986), *cert. denied*, 479 U.S. 1089 (1987) turned to the Code of Federal Regulations to reach its

decision, since "the statute itself fails to provide the answer," saying that the regulations are entitled to "considerable deference." *Id*, at 870. In doing so, the court explored the logic behind these regulations and their conformity with the purposes of ERISA:

> One of the purposes of ERISA was to correct the abuses occurring in the management of pension plans that constitute the retirement benefits held in trust for workers in traditional employer-employee relationships. . . . Employees in the traditional employer-employee relationship are more vulnerable than partners in a partnership are to abuses because workers typically lack control over pension plan management and input into the decision whether to extend pension benefits to certain employees. . . . On the other hand, a partner has more control and input than does an employee since a partner has a vote in partnership affairs. *Robertson*, 798 F.2d at p. 870.

This Court validated *Robertson's* approach in *Yates*, 541 U.S. at 20-21, 124 S.Ct. 1344, holding that the Department's regulations, cited above, are determinative of the threshold issue of whether an ERISA plan exists: "Plans that cover only sole owners or partners and their spouses fall outside of [ERISA's] domain. Plans covering working owners and their nonowner employees, on the other hand, fall entirely within ERISA's compass."

The Majority in the instant suit accepts the contention, rejected in *Robertson*, that the "plan" covers employees who are not partners because the

plans applicable to different "classes" are so "intertwined" that they constitute one plan.[3] Faced with identical considerations, the court in *Robertson* responded:

> His argument ignores the fact that the plans, however similar, are two separate plans. The plan covering the partners does not pay any benefits to principals, and the plan covering principals does not pay any benefits to partners. Since the plans are separate, the plan covering partners covers only partners, and the district court correctly ruled that the plan does not cover employees other than partners. *Robertson*, 798 F.2d at 871-872.

In *Robertson*, the court made clear that plans which are "nearly identical" will be considered distinct plans as long as they are "two separate plans." *Id*, at 871.

The Majority assumes that the various policies issued by AUL are "intertwined," but this assumption unravels under the weight of the following uncontradicted evidence:

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[3] The cases relied upon by the Majority lend no credence to its finding that ERISA governs: *Yates*, 541 U.S. at 6, 124 S.Ct. at 1335 (The question presented: "Does the working owner of a business . . . qualify as a participant in a pension plan covered by" ERISA?); *Wolk v. UNUM Life Ins. of America*, 186 F.3d 352 (3rd Cir. 1999)(The parties conceded that the policy was an ERISA plan.); and a Texas Federal District Court case, ultimately reversed, that the Majority admits is "not precedential." App. 14a.

(1) Individual long term disability insurance policies were issued to each of the partners (Class 1), non-partner attorneys (Class 2), and other employees (Class 3) of the firm pursuant to a written application (subscription agreement). App. 14a, 169a.

(2) A separate, individual policy was issued to House, in his own name, bearing his own social security number, and bearing the typed inscription on page 1, "Group: **Does Not Apply**." App. 163a.

(3) The firm paid 100% of the premiums of employees, while the firm paid none of the premiums for its partners. The partners, including House, paid 100% of their own premiums with after-tax dollars. App. 14a., 28a, 68a, 169a.

(4) The participation of the partners was completely voluntary; whereas, the participation of the employees was not voluntary. App. 28a, 68a-69a.

(5) The terms of the policies issued to partners were different from the terms of the policies issued to

the non-partner attorneys and the other employees.[4] App. 28a.

(6) Only partners were eligible to participate in the Policy issued to House and the policies of each of the other partners, and only employees were eligible to participate in their polices. App. 28a, 67a-68a, 164a.

(7) The subscription agreement specifically required that the firm pay "at least 25% of the premium for a covered person's LTD coverage," but the partners, including House, were exempt from this requirement. App. 169a.

B. The Majority's decision is in conflict with decisions of the Ninth and Eleventh Circuits.

Ninth Circuit. Virtually the same issues presented in the instant suit were before the Ninth Circuit in *In re Watson*, 161 F.3d 593, 596 (9th Cir. 1998), a case involving the profit sharing plan of a sole

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[4] One differentiation was that the policies issued to the employees tied their benefits to wages (40-hour week), without any bonus or overtime compensation, while the policies of House and the other partners tied their benefits to K-1 Forms, which would include all partnership earnings. Another differentiation was that the definition of "Total Disability" was more generous to the partners and non-partner attorneys than to the other employees. The attorneys were afforded an "own occupation" definition that applied for the entire duration of benefit payments. The non-attorney employees only benefitted from the "own occupation" definition for 36 months. After that, eligibility for benefits was based on an "any occupation" definition. App. 69a, 169a-170a.

corporate shareholder. Just as AUL does here, the sole shareholder in *Watson* took the position that his plan was sufficiently related to the plan covering his nurse employees to warrant ERISA coverage. Citing the same Department of Labor regulations relied upon by the Fifth Circuit in *Robertson*, and by this Court in *Yates*, the Ninth Circuit ruled that "even if the plans were created simultaneously or shared other common characteristics, they are independent plans under ERISA." *Id*, at 596, *fn* 4.

The Ninth Circuit had another opportunity to construe the Department of Labor regulations in *LaVenture v. Prudential Ins. Co. of Amer.*, 237 F.3d 1042 (9th Cir. 2001). The question in *LaVenture* was "whether a disability insurance policy, not originally covered by ERISA, is converted into an ERISA plan merely because a company offers its employees unrelated health insurance coverage." *Id*, at 1045. Prudential's contention was that "in determining whether an employee welfare benefit plan exists, a company's entire benefits program must be considered as a whole." *Id*, at 1045. The Ninth Circuit held that ERISA does not apply to the disability policy that only covered the owners of the business. In reaching its decision, *LaVenture* analyzed and cited with favor *Watson* (summarizing that a "company may offer more than one benefit plan, one covering only the owner of the business and the other covering the business' employees, and maintain those two plans as independent plans under ERISA," *id*, at 1046) and *Robertson* (in support of its ruling that Prudential had not established that the disability policy and the health plan were "intertwined so as to constitute one overall benefit plan," *id*, at 1047).

Eleventh Circuit. *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102 (11th Cir. 1999) involved the reversal of an overzealous federal district court that had recharacterized Slamen's claims under his disability policy as ERISA claims. Slamen's solely-owned dental practice had provided health insurance for himself and his employees for a number of years before he obtained disability insurance only for himself. Slamen's professional corporation paid premiums under both the health and disability policies.

Citing the Department of Labor regulations, *Slamen* found that plans under which no employees participate are not employee welfare benefit plans under Title I of ERISA. "Thus, in order to establish an ERISA employee welfare benefit plan, the plan must provide benefits to at least one employee, not including an employee who is also the owner of the business in question." *Id,* at 1104. The court found that Slamen's disability insurance covered only himself. It rejected the arguments of the insurance company that the court should consider the overall insurance coverage and that the premiums were paid by Slamen's professional corporation.

Although *Slamen* noted that the health and disability policies were "purchased at different times, from different insurers, and for different purposes," a phrase seized upon by the Majority, it emphasized that the key to the decision was that the health policy covered Slamen's employees as well as himself, while the disability policy covered only Slamen and did not benefit employees. *Id*, at 1105. *Slamen*'s analysis of the holdings of the following cases reinforces this

emphasis: *Kemp v. IBM Corp.*, 109 F.3d 708 (11th Cir. 1997) ("We held that 'non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits.'"); *Zeiger v. Zeiger*, 131 F.3d 150 (9th Cir. 1997)("'A non-ERISA plan is not converted into an ERISA plan merely because an employer also sponsors a separate benefits plan subject to ERISA.'"); *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986)("The court rejected the argument that ERISA applied because the plan also covered principals, a class of employees, finding that this claim ignores the fact that the plans, however similar, are two separate plans."); *In re Watson*, 161 F.3d 593 (9th Cir. 1998)("treating benefit plan that only provided benefits to physician owner separately from plan for nurse employees because 'they are independent plans under ERISA'"). *Id*, at 1105.

II. IS FEDERAL COMMON LAW, AS HELD BY THE FIFTH CIRCUIT, OR LOUISIANA INSURANCE REGULATORY LAW, AS MANDATED BY CONGRESS, APPLICABLE TO HOUSE'S DISABILITY CLAIM UNDER ERISA'S INSURANCE SAVING CLAUSE, THE RULES OF DECISION ACT, AND ERIE DOCTRINE?

Constitutional principles of comity and federalism embodied in diversity jurisdiction (or ERISA's Insurance Saving Clause, if ERISA is ultimately found to apply to the policy at issue) and the "Conformity With State Laws" provision of the policy support the conclusion that the instant suit falls within the purview of the Rules of Decision Act (28 U.S.C. 1652),

requiring that Louisiana substantive law determine the outcome of this case. App. 157a. The Majority's failure to recognize and apply Louisiana law negates those principles and effectively overrules the express will of Congress contained in ERISA's Insurance Saving Clause.

The Rules of Decision Act, first enacted by Congress in 1789 as part of the Federal Judiciary Act, provides that the "laws of the several states, except where the Constitution or treaties of the United States or Acts of Congress otherwise require or provide, shall be regarded as rules of decision in civil actions in the courts of the United States, in cases where they apply." The landmark case of *Erie R. Co. v. Tompkins*, 304 U.S. 64, 58 S.Ct. 817, 82 L.Ed. 1188 (1938), interpreted the Rules of Decision Act to include not only state statutes, but also controlling judicial decisions of the state.[5] *Erie* was a departure from and a reversal of *Swift v. Tyson*, 41 U.S. 1, 16 Pet. 1, 10 L.Ed. 865 (1842), decided almost a century before, which had limited the application of the Act to those laws passed by the state legislature.

The ruling by the Majority in our case harkens back to the days before *Erie* when, as expressed by Justice Brandeis, the federal courts were allowed to make modifications of the substantive law of a state: "[T]he doctrine of *Swift v. Tyson* is, as Mr. Justice

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[5] "The authority and only authority is the State, and if that be so, the voice adopted by the State as its own (whether it be of its legislature or of its Supreme Court) should utter the last word." *Erie*, 304 U.S. at 79, 58 S.Ct. at 823.

Holmes said, 'an unconstitutional assumption of powers by the Courts of the United States which no lapse of time or respectable array of opinion should make us hesitate to correct.'" *Erie*, 304 U.S. at 79, 58 S.Ct. at 823. *Erie* and its progeny involve fundamental constitutional questions of comity and federalism that are of concern to this day.

Pursuant to the Rules of Decision Act and the *Erie* Doctrine, state law must be applied unless (1) an act of Congress conflicts with state law, or (2) a duly promulgated federal rule of procedure conflicts with a non-substantive right under state law (Rules Enabling Act, 28 U.S.C. 2072). Since neither of these exceptions applies to our case, the court below had a duty to adopt the applicable principles of Louisiana law without regard to its notions of what made "common sense" or what it believed the result ought to have been. Instead, as the dissent below amplifies, the court below failed in this duty, "brushing aside the law of the state in conflict with their views," *Erie*, 304 U.S. at p. 78, 58 S.Ct. at 822.

ERISA's Preemption Clause, set out in 29 U.S.C. § 1144, broadly states that ERISA preempts state laws to the extent they "relate to" employee benefit plans. However, this preemption is limited by an exception recognizing and enforcing state laws that regulate insurance. This Saving Clause permits the state to regulate the terms and conditions of health and disability policies through such laws as La. Rev. Stat.

22:230,[6] protecting total disability benefits, and La. Rev. Stat. 22:213(B)(7) and 22:215(A)(1)(d),[7] protecting accrued benefits.[8] *Kentucky Assn. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-342, 123 S.Ct. 1471, 1479, 155 L.Ed.2d 468 (2003) holds that a state law regulates insurance when (1) it is directed towards entities engaged in insurance, and (2) it affects the risk pooling arrangement between the insurer and the insured. The sections of the Louisiana Insurance Code, cited above and at issue here, meet the *Miller* tests and receive the full protection of ERISA's Insurance Saving Clause.

The twin aims of the Erie Doctrine were enumerated by this Court in *Gasperini v. Center for Humanities, Inc.*, 518 U.S. 415, 428, 116 S.Ct. 2211, 2220, 135 L.Ed.2d 659 (1996): "discouragement of forum-shopping and avoidance of inequitable administration of the laws." Whether or not House's policy is held to be an ERISA plan, the same state insurance regulatory laws apply. Under such circumstances, the outcome of the case should be

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[6] The Majority holds that 22:230 is an insurance-regulating law covered by the Saving Clause. App. 21a–22a, *fn.* 9.

[7] The Majority "assumes without deciding" that La. Rev. Stat. 22:213(B)(7) and, by extension, 22:215(A)(1)(d) are insurance-regulating state laws covered by the Saving Clause. App. 23a.

[8] The purpose of the Louisiana Insurance Code is to regulate the insurance industry in the public interest. La. Rev. Stat. 22:2. No person is permitted to transact the business of insurance in Louisiana without complying with the provisions of this Code. La. Rev. Stat. 22:3

exactly the same as would be reached by a Louisiana court irrespective of whether the case is in federal or state court and irrespective of whether the policy is or is not governed by ERISA.

The inequity of the court below's "brushing aside" of Louisiana law also disregards the Policy itself that specifically provides for "conformity with state laws." AUL declares in its policy that, to the extent that any provision of the Policy is "in conflict with the laws of the state in which it is delivered," such provisions "are amended to conform to the minimum requirements of those laws." Louisiana provides minimum standards of coverage for total disability benefits as well as for accrued benefits. The majority fails to enforce those minimum standards, thus allowing AUL to trample with impunity the express terms of its own contract.

A. The Fifth Circuit has judicially overruled the legislative will of Congress expressed in the Saving Clause.

The Majority has applied federal common law, detailed below, rather than Louisiana insurance regulatory law, to the facts of the instant case even though ERISA's Insurance Saving Clause expressly provides that the Preemption Clause shall not be "construed to exempt or relieve any law of any State which regulates insurance." The effect of this ruling by the Fifth Circuit is to judicially overrule the express legislative will of Congress. Such *ad hoc* action necessitates a review by this Court.

In contrast, the Fourth Circuit states that it would only apply federal common law to ERISA in cases (1)

where "state laws are preempted because they 'relate to' employee benefit plans and because *they do not 'regulate' the insurance industry*" and (2) where "ERISA does not provide any guidance on the issue before the court." *Phoenix Mut. Life Ins. Co. v. Adams*, 30 F.3d 554, 559 (4th Cir. 1994), *emphasis supplied*. Consistent with this reasoning, the Fourth Circuit analyzed the South Carolina law to determine if it "regulates" the insurance industry, thereby saving it from preemption. After thorough consideration, the circuit court found that the law did not merit the protection of the Saving Clause. Only after making that determination did the court consider, and ultimately allow, the application of a "federal common law doctrine of substantial compliance."

In *Travelers Cas. and Sur. Co. v. Iada Services, Inc.*, 497 F.3d 863 (8th Cir. 2007), the Eighth Circuit refused to grant a federal common law right of contribution against a fiduciary under ERISA even though state law claims were preempted by the federal statute. *Travelers* cited cases from the First, Third, Fourth, Fifth and Sixth Circuits supporting the proposition that "federal courts may adopt a common law principle under ERISA 'only if necessary to fill in interstitially or otherwise effectuate the statutory pattern enacted in the large by Congress.'" *Travelers*, 497 F.3d at 865. This circuit court decision also relied on several Supreme Court cases that expressed reluctance to "'tamper with [the] enforcement scheme embodied in the statute by extending remedies not specifically authorized by the text.'" *Travelers*, 497 F.3d at 865-866.

The Fifth Circuit is out-of-step with these Federal Circuits and, more significantly, is beyond the boundary of the comprehensive ERISA statutory system enacted by Congress.

B. House is totally disabled under Louisiana law.

1. The Policy issued by AUL to House.

The policy language pertinent to a determination of total disability provides:

> TOTAL DISABILITY and TOTALLY DISABLED mean that because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation.
>
> PARTIAL DISABILITY and PARTIALLY DISABLED mean that because of Injury or Sickness the Person, while unable to perform every material and substantial duty of his regular occupation on a full-time basis, is:
>
> 1. performing at least one of the material and substantial duties of his regular occupation or another occupation on a part-time or full-time basis . . . .
>
> * * * *
>
> CONFORMITY WITH STATE LAWS: Any provisions of this policy in conflict with the laws of the state in which it is delivered are amended

to conform to the minimum requirements of those laws.

App. 164a-165a, 167a.

2. The Majority's failure to apply Louisiana law.

Giving the terms in the definition of Total Disability their "ordinary and generally accepted meaning" and citing only a single Fifth Circuit (Texas) case rather than Louisiana precedent, the Majority finds the "definitions of total and partial disability under the AUL policy are . . . mutually exclusive." App. 18a-19a. The Majority opines that the disability can be "either total or partial but never both." App. 21a. A Louisiana law analysis, not to mention a review of the plain language of the Policy, demonstrates otherwise.

The Majority continues: "We find the district court's distinction between 'trial lawyer' and 'lawyer' too fine under a common sense interpretation of 'regular occupation.'" App. 19a. In support of this conclusion, the majority cites federal cases from the Sixth Circuit and federal district court decisions from Nevada, California, New York, and Michigan, but not one from Louisiana. App. 19a-20a. The Majority can find no support in Louisiana insurance case or statutory law for its conclusory findings.

Finally, while devoting only one paragraph of its lengthy opinion to La. Rev. Stat. 22:230, the majority fails to cite a single Louisiana case, and ultimately misconstrues the meaning and effect of this statute, which is so critical to a determination of total

disability. App. 21a-22a. This Court would be hard-pressed to find a more compelling example of a federal court erring by failing to apply state statutory law and judicial precedent. Federal common law, or whatever law was patched together by the Majority below, cannot trump Louisiana substantive law and doing so is contrary to long-established Constitutional and statutory mandates of the principles of federalism.

3. The correct interpretation under Louisiana law.

A proper Louisiana law analysis would have led to the correct conclusion: House is totally disabled from his regular occupation as a trial attorney.

The policy at issue was written by AUL using its own standard forms. In *Mayo v. State Farm Mut. Ins. Co.*, 869 So.2d 96 (La. 2004), the Louisiana Supreme Court summarized the Louisiana principles applicable to the interpretation of ambiguities in insurance policies:

> "Ambiguous policy provisions are generally construed against the insurer and in favor of coverage. Under the rule of strict construction, equivocal provisions seeking to narrow an insurer's obligation are strictly construed against the insurer. . . . The determination of whether a contract is clear or unambiguous is a question of law." *Mayo*, 869 So.2d at p. 100, *citations omitted*.

In interpreting the AUL policy, all principles of Louisiana law lead to the conclusion of the trial court, and the appellate dissent, that total disability applies.

The definitions of total and partial disability are far from being mutually exclusive. On the one hand, Total Disability is defined to mean "the Person cannot perform the material and substantial duties of his regular occupation." On the other hand, Partial Disability is defined to mean"the Person, while unable to perform every material and substantial duty of his regular occupation on a full-time basis, is . . . performing at least one of the material and substantial duties of his regular occupation *or another occupation* . . . ." With the addition of the words "or another occupation," the definition of Partial Disability is so broadly drawn that, read literally, there will be countless instances where a person, though unable to perform the "material and substantial duties of his regular occupation," can perform at least one of the "material and substantial duties" of "another occupation."

The interpretation of the policy definitions of total and partial disability by the Majority as being "mutually exclusive" eliminates any realistic chance of a beneficiary qualifying for total disability benefits absent a state of complete helplessness, because the definition of partial disability has been drawn so broadly that it would subsume the definition of total disability altogether. This interpretation of total disability by the Majority directly conflicts with La. Rev. Stat. 22:230(B), which prohibits the definition of total disability from being based solely upon an

individual's inability to perform "any occupation whatsoever."

The Louisiana Supreme Court has consistently rejected restrictive definitions of total disability that, as here, would base recovery on a finding that an "insured is reduced to a state of abject helplessness." *Laborde v. Employers Life Ins. Co.*, 412 So.2d 1301, 1304 (La. 1982); *Johnson v. State Farm Mut. Auto. Ins. Co.*, 342 So.2d 664, 667 (La. 1977); *Nomey v. Pacific Mut. Life Ins.* Co., 212 La. 820, 33 So.2d 531, 534 (La. 1948); *Madison v. Prudential Ins. Co. of America*, 190 La. 103, 181 So.871, 875 (La. 1938); *Boughton v. Mut. Life Ins. Co.*, 183 La. 908, 165 So. 140, 143 (La. 1935); *Crowe v. Equitable Life Assur. Society of U.S.*, 179 La. 444, 154 So. 52 (La. 1934). Beginning with *Crowe, supra,* in 1934, definitions unlawfully limiting the definition of total disability have been construed to mean the "inability to perform the substantial and material part of his occupation *in the usual and customary way.*" *Laborde*, 412 So.2d at. pp. 1302, 1304, *emphasis supplied.*

The Majority's interpretation of "regular occupation" as synonymous with "general occupation," rejecting the district court's distinction between "trial lawyer" and "lawyer," likewise cuts against the grain of Louisiana's judicial precedent. The Louisiana Supreme Court has soundly rejected such a restrictive definition of total disability. Pointedly in *Madison v. Prudential Ins. Co. of America*, 181 So. at pp. 874-875, Louisiana's highest court found a lawyer whose work was chiefly as a trial lawyer to be totally and permanently disabled even though he was able to do some "light" work as a lawyer, noting that a "lawyer

who is able to do only 'light' work will soon find himself without even 'light' work to do." This same reasoning is followed in virtually all of the supreme court cases following *Crowe*, considered to be the seminal Louisiana case for subsequent disability interpretations.[9]

Moreover, La. Rev. Stat. 22:230(C) applies a "former earning capacity" standard, further limiting the insurer's discretion in defining total disability: "A general definition of total disability in such a policy shall not be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation . . . which provides him with substantially the same earning capacity as his former earning capacity prior to the start of the disability." In fact, La. Rev. Stat. 22:230(A) emphasizes that the purpose of such policies is to "provide loss of income protection against total disability."

Apparently realizing that it had not addressed the "former earning capacity" standard, the majority

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[9] *Crowe*, 154 So. at p. 54, found a manual laborer to be totally disabled even though he was able to perform "light work." *Boughton*, 165 So. at p. 143-144, found the manager of a large farm to be totally disabled even though he continued to manage the farm with the assistance of tenants and relatives. *Nomey*, 33 So.2d at p. 534, found a merchant and cotton buyer to be totally disabled where he had lost most of his hearing. *Johnson*, 342 So.2d at p. 667, found a sawyer's total disability to be continuous despite the fact that he returned to work for a period of 17 weeks. *Laborde*, 412 So.2d at p. 1304, found a "journeyman carpenter" to be totally disabled even though he was able to work as a "carpenter inspector/supervisor."

engages in speculation, lacking any supporting facts whatsoever, that "House might have switched to a more sedentary non-trial practice and still earned substantially more than he now does." App. 22a. By engaging in such speculation, the majority avoids consideration of the economic standard expressed in La. Rev. Stat. 22:230(C), a statute which provides powerful support for a ruling in favor of House on the issue of total disability.

Finally, La. Rev. Stat. 22:230(D) authorizes an insurer to specify the requirement of the "complete inability of the individual to perform all of the substantial and material duties of his regular occupation or words of similar import." AUL can not take any solace in this statutory authorization since defining total disability as the inability to "perform the material and substantial duties of his regular occupation" leaves out the determinative prefatory language, "complete inability to" perform. The statute states that an "insurer may specify." If a sophisticated drafter of a policy, like AUL, had meant to insert such language, it is reasonable to expect that it would have done so. AUL did not. The Majority has itself inserted the operative words into the contract for AUL, contrary to the Louisiana rule of law that ambiguities in an insurance policy are to be interpreted "against the insurer and in favor of coverage." *Mayo*, 869 So.2d at p. 100.

C. House cannot be deprived of accrued benefits by AUL and his former law firm.

1. The Majority's failure to apply Louisiana law.

Perhaps the most blatant inequity in the Majority opinion is the notion that accrued partial disability benefits can be stripped away from an insured at the whim of his employer, with the complicity of the insurance company having financial responsibility to pay the claim. As House appreciates the attenuated treatment given this important issue by the Majority, the decision to deprive House of any benefits under his policy after February 28, 2002, hinged upon two slender threads.

The first thread is an artificial, parsing and irrelevant distinction between cancellation and termination. The Majority seems to be suggesting that the two provisions of the Louisiana Insurance Code (Sections 22:213(B)(7) and 22:215(A)(1)(d)) only protect accrued benefits "against the contingency of the policy's subsequent unilateral cancellation by the insurer," not "the policy's subsequent termination, which we have defined in this context as 'cessation of coverage under an insurance contract by reason of the passage of the policy period or the occurrence of some event anticipated by the terms of the contract.'" App. 23a.

The second thread suggests that House did not have any accrued partial disability benefits to be "prejudiced" because the "only benefit House accrued under the policy was the right to receive payment for

his partial disability until the policy was terminated." App. 155a–156a. House's rights should not be abridged based upon such slender threads, especially when they do not hang from either the terms of the policy or prevailing Louisiana law.

2. The correct interpretation under Louisiana law.

No doubt exasperated by the treatment of its founding partner, House's former firm severed its relationship with AUL as of February 28, 2002. AUL claims that this occurrence rendered the partial disability benefits of his disability policy worthless. The Majority gives its blessing by disregarding Louisiana law protecting accrued benefits.

La. Rev. Stat. 22:213(B)(7) prohibits an insurer from cancelling an individual disability policy to the extent such cancellation would prejudice "benefits accrued." The statute defines "benefits accrued" to mean "an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice."

La. Rev. Stat. 22:215(A)(1)(d) transports this prohibition against prejudicing "benefits accrued" from the sphere of the individual disability policy to that of the group disability policy. Under this application of the rule, neither the policyholder (House's former firm) nor the insurer (AUL) can "modify, amend, or cancel the group policy" if doing so will prejudice "any claim for benefits accrued." The definition of "benefits accrued" remained the same under 22:215(A)(1)(d) as under 22:213(B)(7).

The Majority's conclusion notwithstanding, House's right to partial disability benefits had definitely accrued under both statutory definitions of "benefits accrued." House had transmitted his claim to AUL, with appropriate medical support, more than a year prior to the decision by House's former firm and AUL to part ways. Not only did AUL have notice prior to cancellation, but it had actually paid nine months of "good faith"[10] benefits under the policy. In order for AUL to prevail on this issue, the two statutes would have to be written out of Louisiana law. Such is the effect of the majority opinion.

The policy itself pretermits any argument that there is an important distinction between "cancellation" and "termination" requiring House's partial disability benefits to be terminated early. The policy provides under the heading "Termination of a Participating Unit" that insurance will cease on the earliest of nine distinctly defined dates. These dates include: "the end of a Coverage Month, provided that AUL has given at least 60 days prior written notice to the Participating Unit;" or "the end of a Coverage Month, if the Participating Unit has given AUL at least 31 days prior written notice." Thus, under the Policy, a cancellation by the insurance company is considered to be a "termination" and a cancellation by the Participating Unit is likewise considered to be a "termination." There is no distinction between "cancellation" and "termination," as suggested by the

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[10] The district court made over 35 pages of factual findings that AUL was in "bad faith." App. 72a-100a, 127a-136a.

Majority, or, more aptly stated, it amounts to a distinction without a difference. App. 165a-166a.

Following these provisions, the policy adds the following, self-imposed restriction: "Termination of the policy, or termination of coverage for a Participating Unit, *under any conditions* will be without prejudice to any claim originating prior to termination." App. 166a, *emphasis supplied*. If this were not enough, as if for emphasis, the Policy goes further:

> AMENDMENT AND CHANGES: The policy may be amended by mutual agreement between the Group Policyholder, the Participating Unit and AUL, but without prejudice to any loss incurred prior to the effective date of the amendment. . . . [App. 167a.]

Thus, the policy contains its own definitive language prohibiting any cancellation/termination of the policy that would prejudice accrued benefits, defined as "any claim originating prior to termination." App. 166a-167a.

Soniat v. Travelers Ins. Co., 538 So.2d 210 (La. 1989), a decision of the Louisiana Supreme Court whose factual context predated the applicable language in 22:215, conflicts in every respect with the Majority opinion on this issue. The Louisiana Supreme Court in *Soniat*, finding 22:213 to be incorporated into 22:215 by reference (La. Rev. Stat. 22:215(C)), interpreted 22:213 as allowing plaintiffs to recover the medical expenses for the delivery of their child when the pregnancy occurred before, but the delivery occurred after, the group policy was cancelled

because of the failure of the employer to pay premiums. *Soniat*, 538 So.2d at p. 215. In that case, the Louisiana Supreme Court reversed the lower court's rejection of benefits based upon the same distinction between cancellation of the policy and termination of coverage of the beneficiary that the Majority erroneously utilizes here.

The pertinent events in *Soniat* occurred during the first half of 1984. At that time, 22:213(B)(7) stipulated that a cancellation "shall be without prejudice to any claim originating prior thereto," language almost identical, word-for-word, to that contained in the AUL policy, "will be without prejudice to any claim originating prior to termination."[11] *Soniat*, 538 So.2d at p. 216. Under Section 213(B)(7), the cancellation was without prejudice to the claim for medical expenses of the pregnancy, where the risk was known prior to the cancellation of the policy. *Soniat*, 538 So.2d at. p. 215. La. Rev. Stat. 22:215 legislatively ratifies *Soniat* and provides even greater reason to hold in favor of House on this issue.

Cataldie v. Louisiana Health Service, 456 So.2d 1373 (La. 1984) reached the same conclusion as the court in *Soniat* where plaintiff's daughter contracted brain cancer. After learning of the cancer, the insurance company drastically modified its policy of

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[11] The fact that these two provisions are almost identical no doubt stems from the fact that the Louisiana statutory clause was "adopted with only minor deviations from the Uniform Individual Accident and Sickness Policy Provisions Law." *Cataldie v. Louisiana Health Service*, 456 So.2d 1373, 1375 (La. 1984).

health insurance. The Louisiana Supreme Court found such change to be invalid. In considering the meaning of "benefits accrued," the court stated:

> "Perhaps in a narrow sense of esoteric legal doctrine Cataldie's claim originating before cancellation could be said to be restricted to medical bills rendered on or before this date. We do not believe the statute should be given such a confined interpretation. . . . Cataldie had a claim for major medical services related to his daughter's cancer of which the insurer was notified and which originated before it cancelled the policy." *Cataldie,* 456 So.2d at p. 1376.

The history of 22:213(B)(7) shows that it was formulated "to serve as a safeguard against unconscionable cancellation of health insurance policies by an insurer after the occurrence of illness or injury but before the loss had fully accrued." *Cataldie*, 456 So.2d at p. 1376. The legal principles, expressed by Louisiana's highest court, are binding in reaching the correct outcome on this issue.

One final point: The designation in all caps and bold on page one of the Certificate of Insurance labels the insurance as "**GROUP LONG TERM DISABILITY INSURANCE**." App. 164a. It seems antithetical to have House declared to be partially disabled under his *long* term disability Policy, while at the same time validating the ability of third parties, AUL and House's former firm, to cut those benefits *short*.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully Submitted,

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APPENDIX

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 06-30168

[Filed September 4, 2007]
Revised September 21, 2007

WALTER RICHARD HOUSE, JR., Plaintiff-Appellee-Cross-Appellant,	)
versus	)
AMERICAN UNITED LIFE INSURANCE COMPANY, Defendant-Appellant-Cross-Appellee.	)

Appeals from the United States District Court for the Eastern District of Louisiana.

Before REAVLEY, GARZA and DENNIS, Circuit Judges.

REAVLEY, Circuit Judge:

Walter House sued American United Life Insurance Company ("AUL") for long-term disability benefits. The district court granted summary

judgment by which total disability benefits and a Louisiana state law penalty were awarded to House. We hold that House's claim comes under an ERISA plan that preempts the state law penalty and that he was only partially disabled.

I. Background

Walter House was a trial attorney and founding partner of his firm, earning approximately $350,000 per year. In October 1999, at age forty-nine, House suffered a heart attack. In that same month, House's law firm sought competitive proposals from several insurers to provide more affordable life and disability insurance for the entire firm, including attorneys and staff.

The firm entered into a subscription agreement for group life and disability coverage with AUL, providing for one class of life insurance coverage and three classes of disability coverage: Class 3 covering non-attorney employees, Class 2 covering non-partner attorneys, and Class 1 covering partners. The disability coverage for partners and non-partner attorneys was identical, except that (1) partners would contribute 100% of their premiums and their pre-disability earnings would be calculated using K-1 forms[1] rather than W-2s; and (2) the definition of total disability for the partner and non-partner attorneys (Classes 1 and 2) differed slightly from that applicable to the other non-attorney employees (Class 3). For

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[1] Internal Revenue Service Schedule K-1 (Form 1065), "Partner's Share of Income, Deductions, and Other Items."

attorneys, that term meant that "because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation." For the other employees, totally disabled meant that he or she "cannot perform the material and substantial duties of any gainful occupation for which the Person is reasonably fitted by training, education, or experience."

Under the agreement, total disability benefits for all classes would replace the covered person's pre-disability monthly income up to $10,000, but subject to dollar-for-dollar reduction for other employment earnings. Partial disability benefits would be calculated through a stated formula, which yielded a percentage of the covered person's pre-disability income as reduced by other income and not to exceed a maximum $10,000 per month. Partial disability benefits would be subject to discontinuation upon the firm's termination as a "Participating Unit" in AUL's insurance trust—in other words, when the firm no longer maintained insurance through AUL.

The firm provided AUL with enrollment materials for all participants in the life and insurance coverage. On his enrollment form, House filled in his occupation as "Attorney." Because of House's cardiac problems, AUL required a letter from his doctor stating that he was able to return to work full-time with no restrictions before it would approve the group coverage. House's physician provided AUL a letter stating that House's prognosis was excellent and that he could return to work without any limitations. AUL notified the firm that the insurance application for the "group" had been approved and provided a rate exhibit

stating the premium rates for all the coverage made available through the group policy. There was no distinction in rates between partners, associates, or staff, but rather a per-coverage-dollar rate for the entire group.

AUL provided certificates of insurance for delivery to the insured individuals, including House. The certificate House received, like the certificates all other firm participants received, describes the disability coverage he was provided, but references the group policy as the source of all rights and benefits, that policy being subject to cancellation or termination by the firm or AUL. Under the group policy, the firm undertook responsibility for certain administrative tasks including determining eligibility for participation, enrollment of participants, calculation of premiums, and payment of premiums. The firm submitted a single premium check to AUL each month, deducting the partner's disability premiums from their draw accounts.

About a month after his October 1999 heart attack, House returned to his trial practice, but a year later he failed stress tests and subsequently underwent quadruple bypass surgery. He briefly returned to work in November 2000, but only to wind up his trial practice and reassign his clients, after which he left the firm. In October 2001, House accepted a position as executive counsel to the Louisiana Department of Economic Development, a non-litigation position that paid him $100,000 per year.

House initially applied for benefits under the AUL policy in November of 2000, contending that he was

totally disabled because his doctor advised that returning to the stress of trial work could cause severe medical repercussions, including death. AUL paid nine months' of total disability payments to House from January to September 2001, apparently while evaluating his claim. Initially, AUL told House it would need an independent medical examination to assess his disability claim, but did not ultimately obtain one. Instead, in November 2001 and relying on its policy interpretation, AUL denied House's claim on grounds that, given his post-operative activities and current employment, he appeared to be "capable of performing the sedentary occupation of an Attorney as it is normally performed in the national economy."

House sued, seeking full benefits and, under state law, penalties (related to bad faith refusal to pay, and misrepresentation), and attorneys fees. The parties filed a series of partial summary judgment motions debating ERISA[2] preemption and policy terms, and the district court held:

(1) House's state law claims were not preempted because the policy was not an ERISA plan;

(2) House was totally disabled based on policy language despite his ability to earn substantial income as an attorney;

(3) House also qualified as partially disabled under the policy language, such status being

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[2] Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

not mutually exclusive with total disability as written; and therefore that;

(4) House was entitled to the greater of:

(a) the maximum monthly total disability benefit of $10,000 per month, but subject to offset by his earnings from the Louisiana agency, or

(b) the partial disability benefit as calculated under the policy formula;

(5) partial disability benefits terminated as of February 2002 when House's former firm terminated the firm's policies with AUL;

(6) House was due total disability benefits *without* offset for the time frame of October 2001 to November 2003, when AUL was disputing that it owed benefits, plus a penalty equaling an additional $10,000 for each month AUL did not pay during that time frame;

(7) House was entitled to total disability benefits with offset after the February 2002 termination date of the partial disability benefits because of the court's earlier determination that House was entitled to the greater of total or partial disability benefits;

(8) House was entitled to attorneys fees and costs.

Neither party was fully satisfied with the outcome and both appeal. House argues he is entitled to additional penalties and either offset-free total disability benefits or continuing partial disability benefits. AUL argues that the disability policy under which House is claiming benefits is governed by ERISA, state law penalties being therefore preempted, and challenges the district court's finding that House was simultaneously totally as well as partially disabled under the policy.

II. ERISA Governance

We are presented with the threshold question of whether House's disability policy is a benefit plan regulated by ERISA. To determine the answer "we ask whether a plan: (1) exists; (2) falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an ERISA 'employee benefit plan'—establishment or maintenance by an employer intending to benefit employees." *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993).

AUL asserts that House's state law claims for penalties and attorneys fees are preempted because the policy covering House was part of an "employee benefit plan" as defined by ERISA and not exempt under safe harbor. Relying on our decision in *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986), the district court held that the Class 1 disability coverage for partners in House's firm was a separate plan and, since it benefited only partners and not any employees, it was not governed by ERISA and

therefore House was entitled to state law penalties and attorneys fees.

A. Standard of Review

We have frequently stated that the existence of an ERISA plan within the statutory definition is a question of fact. *See, e.g., Meredith,* 980 F.2d at 353. However, where the factual circumstances are established as a matter of law or undisputed, we have treated the question as one of law to be reviewed *de novo*. *See id.* at 355. (stating our purpose as review of the summary judgment record for genuine issues of material fact, but applying the statutory scheme as a question of law to the facts established by the district court and overturning the district court's determination that an ERISA plan existed); *see also Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (holding that when the factual circumstances are undisputed, whether the facts suffice to demonstrate the existence of a plan as defined by ERISA is a question of law to be reviewed *de novo*); JAMES F. JORDEN ET AL., HANDBOOK ON ERISA LITIGATION § 201(A) (3d ed. 2007) ("[W]hen the factual circumstances are undisputed, the existence of an ERISA plan is a question of law to be reviewed *de novo*."). It is clear that, while not so stating, we have followed our sister circuits in treating the existence of an ERISA plan as a mixed question of fact and law.[3]

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[3] *See, e.g., New England Mutual Life Ins. Co., Inc. v. Baig,* 166 F.3d 1, 3 (1st Cir. 1999) ("[T]he district court's interpretation of the word 'plan' as used in ERISA poses a question of law subject to de novo review [but] the court's inquiry into the nature and the

In this case, where the parties concede the existence of the firm's employee welfare benefit plan and the facts relative to whether House's coverage was a part of that scheme or a separate plan were undisputed, the district court's interpretation of the word 'plan' as used in ERISA poses a question of law subject to de novo review.

B. Whether the policy under which House is claiming benefits in this action falls under the safe harbor exclusion.

With respect to the first *Meredith* inquiry (existence of a plan), there is no dispute here that an intentional benefit plan existed at the firm. Thus we begin with the second *Meredith* factor: to qualify as an ERISA plan, the plan cannot fall within the Department of Labor's safe harbor exclusion.[4] The

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scope of the benefits actually at issue . . . demands factfinding, and is to that extent reviewable only for clear error.") (internal quotation and citation omitted); *Kulinski v. Medtronic Bio-Medicus, Inc.*, 21 F.3d 254, 256 (8th Cir. 1994) *abrogated on other grounds by Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341, 123 S. Ct. 1471 (stating that the existence of an ERISA plan is a mixed question of fact and law that on appeal is reviewed *de novo*); *Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043, 1047 n. 5 (10th Cir. 1992) (same).

[4] We begin with safe harbor analysis for the sake of clarity in tracking *Meredith*. We note that, if House's disability coverage were, as he urges, a wholly separate plan comprising non-employees only, it would fall outside of ERISA under prong three of *Meredith* and could not be swept back in by failure to qualify under the safe harbor analysis. In other words, if one's

safe harbor provision states that a group or group-type insurance program will not be considered an ERISA Plan if (1) the employer does not contribute to the plan; (2) participation is voluntary; (3) the employer's role is limited to collecting premiums and remitting them to the insurer; and (4) the employer receives no profit from the plan. 29 C.F.R. § 2510.3-1(j). The plan must meet all four criteria to be exempt from ERISA.

There is no question that, considering the firm's life and disability plan as a whole, the safe harbor exclusion is not met. For Class 2 and 3 employees, participation was mandatory and the firm contributed 100% of the employees' premiums. We believe the same holds true for the Class 1 partner coverage standing alone. First, while the partners paid their own premiums for the optional disability coverage, they benefited from the unitary rate structure the firm was able to negotiate by bargaining for disability coverage as a package for all classes. The partners therefore effectively received a premium discount or constructive contribution from the firm. Second, the firm's role was not, with respect to the Class 1 coverage, limited to merely serving as a conduit for partner premiums. We have found sufficient employer involvement to defeat safe harbor in cases where the employer had a lesser degree of administrative involvement than here. *See, e.g. Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977-78 (5th Cir. 1991).

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objective is, as House's, to prove a non-ERISA plan, establishing that the plan under consideration fails prong three (no employee welfare benefit plan), would render safe harbor analysis moot.

We conclude that neither the multi-class life and disability coverage as a whole nor the specific Class 1 partner coverage meet the safe harbor exclusion. Even if safe harbor is barred, however, that does not necessarily mean that the insurance policy is part of an ERISA plan. A plan that falls outside of the safe harbor exception does not fall within the jurisdiction of ERISA unless it satisfies the third *Meredith* prong. *Hansen,* 940 F.2d at 975.

C. Whether the insurance policy under which House is claiming benefits in this action is part of an employee benefit plan under ERISA.

To meet the third *Meredith* prong, a plan must satisfy the primary elements of an ERISA 'employee benefit plan'—establishment or maintenance by an employer intending to benefit employees. Under ERISA, an employee welfare benefit plan is, in pertinent part:

> . . . any plan, fund, or program, which was . . . or is . . . established or maintained by an employer . . . for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . benefits in the event of sickness, accident, disability, death or unemployment
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> . . . .

29 U.S.C. § 1002(1). "The term 'participant' means any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan. . . ." *Id.* at subsection (2)(B)(7). Department of Labor regulations

specify that any plan under which no employees are covered in not an ERISA plan, 29 C.F.R. § 2510.3-3(b), and that partners who wholly own a business are not normally employees of that business under ERISA, *id.* at subsection (c)(2). *See Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* 541 U.S. 1, 21, 124 S. Ct. 1330, 1344 (2004) ("Plans that cover only sole owners or partners and their spouses . . . fall outside [ERISA's] domain."); *Meredith,* 980 F.2d at 358 (finding no ERISA plan where group insurance policy covered sole proprietor and spouse and no employees); However, a plan covering both working-owner employers or shareholders as well as employees is governed by ERISA. *Yates,* 124 S. Ct. at 1341-42.

We clarify that § 2510.3-3(b) is specifically limited in its application to the determination of the existence of an employee welfare benefit plan. An owner of a business is not considered an "employee" for purposes of determining the existence of an ERISA plan; in other words, ERISA does not govern a plan whose *only* fully vested beneficiaries are a company's owners. *See Yates,* 124 S. Ct. at 1343-44 ("Plans that cover only sole owners or partners . . . fall outside [ERISA's] domain."). However, once an employee benefit plan is established (because other employees are covered by the plan in addition to the owner), a working owner, in common with other employees, is a plan "participant" governed by ERISA.[5] *See Yates,* 124 S. Ct. at 1341-42

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[5] The dissent cites to cases that pre-date *Yates,* which clarified this two-part inquiry, citing and tracking our own reasoning in *Vega v. Nat'l Life Ins. Servs., Inc.,* 188 F.3d 287, 294 (5th Cir. 1999)

("Plans covering working owners *and* their nonowner employees, on the other hand, fall entirely within ERISA's compass.") (emphasis in original).

In *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986), relied upon heavily by the district court in the instant case, we held that a retirement plan benefiting only partners was, despite similarities to a parallel employee plan, distinctly separate and therefore not covered by ERISA. *Id.* at 871-72. In addition to *Robertson,* the district court also relied on *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102 (11th Cir. 1999). In that case, a dentist in a solely owned dental practice purchased separate disability insurance policies for himself and his employees, but at different times and from different insurers. The Eleventh Circuit applied our decision in *Robertson* to hold that Dr. Slamen's insurance policy was separate from the insurance benefits provided to his employees and was not governed by ERISA. *Id.* at 1105. House also directs us to a Ninth Circuit opinion, citing both *Slamen* and *Robertson,* and holding that a disability policy covering only the owners of a business is not converted into an ERISA plan simply because the employer subsequently sponsors a separate ERISA health insurance benefits plan for its employees. *LaVenture v. Prudential Ins. Co.*, 237 F.3d 1042, 1046-47 (9th Cir. 2001). The court found no evidence that the disability policy and the unrelated health plan were so intertwined as to constitute one overall benefit plan. *Id.* at 1047.

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in determining that a working owner may qualify as a participant in an employee benefit plan covered by ERISA.

We find no previous instance in which we have considered the application of *Robertson* to a multi-class group insurance policy where one class comprises only owners or partners. While the scheme established by House's firm (employer-paid disability coverage for non-partners with optional disability coverage available to partners at their own expense) appears to be a common one, there is a dearth of precedent on whether the partner class constitutes a separate non-ERISA plan. We note that in *Wolk v. UNUM Life Ins. of America,* 186 F.3d 352, 355 (3d Cir. 1999), under nearly identical facts—a multi-class disability policy under which partners paid for their own premiums for optional coverage—the parties conceded that the policy was an ERISA plan. Although not precedential, we find a Texas district court case instructive because of its equal similarity to the facts of the instant case. *See Lain v. UNUM Life Ins. Co.,* 27 F. Supp 2d 926 (S.D. Tex. 1998), *rev'd on other grounds* 279 F.3d 337 (5th Cir. 2002). Lain was a partner in a law firm[6] that elected to provide disability insurance for all of its employees. *Id.* at 927. Insurance for partners under the same policy was optional and the partners paid the cost of their insurance. *Id.* at 927-28. The district court concluded that although Lain was not a "participant" as defined by ERISA for the initial purposes of establishing existence of an ERISA plan under 2510.3-3(b), she was a "beneficiary" of a plan including both employees and partners and therefore had standing to sue under ERISA. *Id.* at 934. ("The LTD plan expressly covers

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[6] More precisely, Lain was the sole shareholder of Ellen Lain, P.C., which in turn was a partner in the law firm.

partners who pay their own premiums. Because Lain paid her premiums, she was a beneficiary under the plan.").

Ultimately, guided by *Yates, Wolk*, and *Lain,* we find this case distinguishable from *Robertson, Slamen*, and *LaVenture.* In each of those cases, separate and distinct plans were maintained exclusively for owners. Here, the record reflects that the partner-class disability coverage was part of a comprehensive employee welfare benefit plan covering both partners and employees. The AUL life and disability insurance was bargained and paid for as a package by the firm, through a single subscription agreement resulting in a group policy. The policy contemplates and establishes a single plan, with the only distinctions between classes being the method of determining pre-disability earnings—since partners' variable, non-salary income would have to be calculated differently—and a more generic disability description to accommodate the variable occupations of the non-attorney participants. The rights of House as well as all non-partner attorneys and firm employees, while spelled out in their individual certificates of insurance, arose from the group policy.

The firm contributed 100% of the premiums for all non-partner participants and administered the entire insurance coverage for all classes of insureds. And as discussed above, while the partners paid their own premiums, they benefited from the unitary rate structure the firm was able to negotiate bargaining for the disability coverage as a package, effectively receiving a constructive contribution from the firm. We therefor do not find the partners' premium

contributions enough to establish the partner-class disability coverage as a separate plan under *Robertson* and conclude that the non-partner and partner-class life and disability coverage are sufficiently related and intertwined as to constitute one overall benefit plan. Because that plan benefits both partners and employees, it is governed by ERISA.

The district court's separate-plan holding would mean that partners and non-partner attorneys could assert identical claims relating to identical terms in the identical certificates of insurance issued by AUL and governed by a single subscription agreement, but the partners' disability claims would be governed by state law and the non-partner participants' disability claims would be governed by ERISA. State and federal courts could be asked to read, interpret and apply the same policy provisions for persons in the various disability classes. While we acknowledge that the primary purpose of ERISA is protection of employees,[7] we have recognized the anomaly of requiring some insureds to pursue benefits under state law while

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[7] Congress enacted ERISA to correct abuses occurring in the administration of private retirement plans and ex plans. *Robertson v. Alexander Grant & Co.*, 798 F.2d 868, 870 (5th Cir. 1986) (citing S. Rep. No. 127 93d Cong., 2d Sess., *reprinted in* 1974 U.S.C.C.A.N. 4838, 4838-44). Employees in the traditional employer-employee relationship are more vulnerable to abuses because they lack control and input over pension plan management. *Id.* This concern does not arise where the benefit plan covers only the employer; such plans are excluded from ERISA's broad scope because when the employee and employer are one and the same, there is little need to regulate plan administration. *Id.*

requiring others covered by the identical policy to proceed under ERISA as out of keeping with Congress's intent of achieving uniformity in the law governing employment benefits. *Hollis v. Provident Life and Accident Ins. Co.*, 259 F.3d 410, 416 (5th Cir. 2001); *see also Yates*, 541 U.S. at 17-18, 124 S. Ct. at 1341-42 ("Recognizing the working owner as an ERISA-sheltered plan participant also avoids the anomaly that the same plan will be controlled by discrete regimes: federal-law governance for the nonowner employees; state-law governance for the working owner . . . Excepting working owner's from the federal Act's coverage would generate administrative difficulties and is hardly consistent with a national uniformity.") (citations omitted).

Because we conclude that the disability policy covering House was part of an ERISA plan, House's state law claims for penalties and attorneys fees are preempted. 29 U.S.C. § 1144(a) ([ERISA's provisions] "supersede any and all State laws insofar as they may . . . relate to any employee benefit plan. . . ."). We therefore do not reach the issue of whether AUL's partial payment of disputed benefits relieved it from obligation to pay penalties.

III. Degree of House's Disability

We turn to the issue of whether the district court erred in finding that House was "totally disabled" under the *policy* and that House could be deemed simultaneously both "totally disabled" and "partially disabled" under the policy. When called upon to interpret an ERISA-covered policy, "we construe the terms of the plan de novo unless the benefit plan gives

the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Wegner v. Standard Ins. Co.*, 129 F.3d 814, 818 (5th Cir. 1997) (internal quotation and citation omitted). As the record in this case reveals no such grant of discretionary authority to a fiduciary or administrator, the language of the policy guides our de novo interpretation. *Id.*

> The policy definitions for Class 1 or 2 insureds (attorneys) provides that:
>
> TOTAL DISABILITY and TOTALLY DISABLED mean that because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation.
>
> PARTIAL DISABILITY and PARTIALLY DISABLED mean that because of Injury or Sickness the Person, while unable to perform every material and substantial duty of his regular occupation on a full-time basis, is:
>
> 1. performing at least one of the material and substantial duties of his regular occupation or another occupation on a part-time or full-time basis; and
>
> 2. is earning less than 80% of his Indexed Pre-Disability Earnings due to that same Injury or Sickness.

Because the terms "material and substantial duties" and "regular occupation" are not defined in the

policy, we accord the terms their ordinary and generally accepted meaning. *Provident Life & Accident Ins. Co. v. Sharpless,* 364 F.3d 634, 641 (5th Cir. 2004). Reading the partial and total disability provisions *in pari materia,* in order to obtain total disability benefits, House would have to demonstrate that he cannot perform all of the material and substantial duties of his occupation. In analyzing similar policy provisions, we have concluded that this means a claimant is totally disabled only if he or she cannot perform each and every material and substantial duty of his or her occupation. *Ellis v. Liberty Life Assurance Co. of Boston,* 394 F.3d 262, 272 (5th Cir. 2004). A claimant is thus partially disabled under this policy if able to perform one or more, but not all, of the material and substantial duties of his or her occupation. *See id.* at 271-72. The definitions of total and partial disability under the AUL policy are therefore mutually exclusive.

We find the district court's distinction between "trial lawyer" and "lawyer" too fine under a common sense interpretation of "regular occupation." A number of courts have upheld an interpretation of "regular occupation" as meaning a general occupation rather than a particular position with a particular employer.[8] Although review of such an interpretation

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[8] See, e.g., *Schmidlkofer v. Directory Distrib. Assoc., Inc.,* 107 Fed. App'x 631, 633-34 (6th Cir. 2004) citing *Ehrensaft v. Dimension Works Inc. Long Term Disability Plan,* 120 F.Supp.2d 1253, 1259 (D. Nev.2000) ("This Court finds that the term, 'occupation,' is a general description, not a specific one. . . . A person may not be able to perform a specific job assignment, but still be able to perform the duties generally understood to be part of his or her

in many cases was deferential, having been made by a plan administrator vested with discretion, we do not believe that precludes a like interpretation here. House's "regular" occupation was as an attorney, not restricted to his own specific job as a litigation attorney with a uniquely stressful practice, but rather referencing the activities that constitute the material duties of an attorney as they are found in the general economy. *See, e.g., Osborne v. Hartford Life and Accident Ins. Co.*, 465 F.3d 296, (6th Cir. 2007) ("Whatever the meaning of 'regular' is, it is not synonymous with "own.").

'occupation.' For example, a secretary is not disabled from his or her 'occupation' just because he or she cannot also perform additional tasks assigned by an employer, such as moving furniture or lifting heavy objects."); *Dionida v. Reliance Standard Life Ins. Co.*, 50 F.Supp.2d 934, 939 (N.D. Cal. 1999) ("The term 'regular occupation' may be fairly construed to mean 'a position of the same general character as the insured's previous job, with similar duties and training requirements.'" (quoting *Dawes v. First Unum Life Ins., Co.*, 851 F.Supp. 118, 122 (S.D.N.Y.1994))); *Hanser v. Ralston Purina Co.*, 821 F.Supp. 473, 478 (E.D.Mich. 1993) ("The court finds that defendant's interpretation of the terms 'regular occupation' as meaning the type of work which a covered employee is trained to perform rather than the specific job at which the employee was working when he became ill, is a rational interpretation supported by the plain meaning of the words."); *cf. Valeck v. Watson Wyatt & Co.*, 266 F.Supp.2d 610, 620-21 (E.D.Mich.2003) (upholding as the interpretation of both "regular job" and "regular occupation" as "the kind of work [insured] did" rather than the "specific job in the specific office and with the specific supervisor and co-workers with whom she worked").

Even crediting the opinion of House's doctor that House's heart condition precludes him from resuming his stressful trial practice, House is clearly able to perform some of the material aspects of his occupation as an attorney, as evidenced by his post-surgery activities with his firm and his current legal employment with the Louisiana agency. Under the policy, this takes House outside of the definition of total disability and places him squarely within the definition of partial disability.

The dissent discusses total disability as if the policy does not at the same time define partial disability. When read together, at the same time the disability can be either total or partial but never both. So when the definition of partial disability fits the condition of House, that is his benefit.

House urges that such an interpretation runs afoul of Louisiana Revised Statute 22:230(C), which provides that "[a] general definition of total disability in [a disability loss of income policy] shall not be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is, or becomes, qualified by reason of education, training, or experience and which provides him with substantially the same earning capacity as his former earning capacity prior to the start of the disability."[9] However, section 22:230(D)

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[9] We note, and AUL concedes, that ERISA preemption does not preclude such argument because, if applicable, section 22:230 directly regulates the business of insurance and substantially

permits an insurer defining total disability to "specify the requirement of the complete inability of the individual to perform all of the substantial and material duties of his regular occupation or words of similar import." As discussed above, the AUL policy's definition of total disability comports with this standard. Further, while House's former occupation as a trial lawyer was clearly more lucrative than some other alternative practices and certainly more lucrative than his new agency job, House might have switched to a more sedentary non-trial legal practice and still earned substantially more than he now does. In sum, we cannot agree that the policy's total disability language is unduly restrictive under Louisiana law.

Because we conclude that House does not qualify as totally disabled under the policy language, we do not reach the issue of whether AUL is entitled to set off House's present earnings against total disability benefits.

IV. Termination of House's Entitlement to Partial Disability Benefits

Finally, we consider the district court's conclusion that partial disability benefits terminated as of February 2002 when House's former firm terminated the firm's policies with AUL. Reviewing the record de novo, we find no error.

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affects the risk-pooling agreements between insurers and insureds. *See* 29 U.S.C. § 1144(b)(2)(A).

"Under Louisiana law, the rights of the beneficiary of an insurance policy depend, first and foremost, on the terms of the policy." *Gonzales v. Prudential Ins. Co. of Am.*, 901 F.2d 446, 454 (5th Cir. 1990).[10] "Supplementing the rights guaranteed to the beneficiary by the insurance contract are others that are established by the provisions of the Insurance Code and the jurisprudential rules that have sprung from it." *Id.* The Louisiana Insurance Code protects a beneficiary's claims for "benefits accrued or expenses incurred" against the contingency of the policy's subsequent unilateral cancellation by the insurer. LA. REV. STAT. ANN. § 22:213(B)(7). The Louisiana Supreme Court has held, *Soniat v. Travelers Ins. Co.*, 538 So.2d 210, 215 (La. 1989), and we have assumed without deciding, *Gonzales*, 901 F.2d at 454, that this insurance-regulating state law provision is not preempted by ERISA. However, these rules do not protect a beneficiary against the contingency of the policy's subsequent termination, which we have defined in this context as "cessation of coverage under an insurance contract by reason of the passage of the policy period or the occurrence of some event anticipated by the terms of the contract." *Gonzales*, 901 F.2d at 455 (citations and internal quotations omitted); *see also Soniat*, 538 So.2d at 215 & n. 12 (recognizing the distinction between cancellation and termination of insurance coverage under Louisiana law).

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[10] Recognized as superseded by statute on other grounds (definition of disability under Louisiana law) as stated in *Guidry v. Northwestern Mut. Life Ins. Co.*, 88 F. App'x 12 (5th Cir. 2004).

The policy covering House clearly contemplated that payment of benefits for a persisting total disability arising during a covered period would be extended throughout the duration of a beneficiary's normal working life. Section 5 of the policy reads: "EXTENDED BENEFIT: If the Person is Totally Disabled on the date of termination of insurance, AUL will pay benefits for Total Disability." However, the insuring provisions of the policy do not provide the same extended coverage for a partially disabling condition, that coverage expressly ceasing upon, among other enumerated events, termination of the firm's coverage under the group policy. Section 8 of the policy reads, in relevant part: "[T]he Partial Disability Benefit will continue until the EARLIEST of the following: . . . 9. The date the policy terminates; or 10. The date the Participating Unit's [the firm's] coverage under the policy terminates." Because, under the terms of the contract, no right to permanent partial disability coverage was bargained or provided for, no right to perpetual partial disability benefits accrued to House prior to the termination of the policy. The cessation of AUL's liability for partial disability payments at the time House's former firm ceased to be a covered "Participating Unit" constitutes a termination rather than a cancellation of coverage and thus does not run afoul of the Insurance Code.

V. Conclusion

This decision rejects the contentions of House's appeal. The case is remanded to the district court for recalculation of what amounts are due House consistent with this opinion.

REVERSED AND REMANDED.

DENNIS, Circuit Judge, dissenting:

Because the majority opinion (1) disregards our holding in *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986) to find that the insurance policy is governed by ERISA and (2) ignores the provisions of Louisiana Revised Statute section 22:230 and Louisiana jurisprudence on total disability policy definitions to conclude that Walter House does not qualify as totally disabled under the policy language, I respectfully dissent.

I. ERISA Coverage

As an initial matter, the majority misstates the standard of review for the question of whether House's insurance policy constitutes an ERISA plan. In *McNeil v. Time Insurance Co.*, 205 F.3d 179, 181 (5th Cir. 2000), we reviewed an identical question in a similar posture. There, a district court had dismissed state law claims on summary judgment on the grounds that a single insurance policy covering both a partner and an employee as beneficiaries constituted an ERISA plan, preempting the state law claims. *Id.* at 189. We applied two different standards: the question of whether the "insurance policy constituted an ERISA plan" was a fact issue reviewed for clear error, while the question of whether ERISA preempted state law claims was a legal one reviewed *de novo*. *Id.*; *see also Provident Life and Acc. Ins. Co. v. Sharpless*, 364 F.3d 634, 638 (5th Cir. 2004). Here, the majority recasts the same question of whether the insurance policy constitutes an ERISA plan as a mixed question of fact

and law that is subject to *de novo* review. Applying *McNeil,* we should review the district court's decision that the partner House's policy was separate from the employees' policy for clear error, and I do not believe that any error here is significant enough to overcome that hurdle.

Under either standard, however, I would affirm the district court's determination that House's policy was not part of an ERISA plan. In *Robertson,* we held that plans benefiting only partners were not covered by ERISA because of the unique negotiating posture a partner assumes vis-à-vis his firm. *Robertson* noted that

> [e]mployees in the traditional employer-employee relationship are more vulnerable than partners in a partnership are to abuses because workers typically lack control over pension plan management and input into the decision whether to extend pension benefits to certain employees. On the other hand, a partner has more control and input than does an employee since a partner has a vote in partnership affairs. Furthermore, a partnership contains a self-policing feature largely absent in the typical employer-employee relationship. In the partnership situation the partners have an incentive not to agree to provisions that may harm certain members of the partnership because each partner knows that he could end up being the partner who is harmed.

798 F.2d at 870.

This logic is especially forceful here. House was not only a partner of the law firm, but a founder with his name in the most prominent position. House's superior control and input as a partner is evident from the facts found by the district court. It noted that House was able to obtain advantages over the policy given to employees. House's income covered by the policy included his entire net income, whereas employees were limited to their base salary under a forty hour workweek. *House v. Amer. United Life Ins. Co.*, No. 02-1342, 2004 WL 856671, at *9 (E.D. La. Apr. 20, 2004). House also was able to secure a much more favorable definition of total disability as compared to his employees. He could be considered totally disabled if "because of Injury or Sickness the Person cannot perform the material and substantial duties of *his regular occupation*," whereas employees could be totally disabled only if they "cannot perform the material and substantial duties of *any gainful occupation* for which the Person is reasonably fitted by training, education, or experience." *Id.* (emphasis added). Under *Robertson*'s rationale, House was not vulnerable to abuse under his policy because of his status as a partner and ERISA was not intended to provide him with protection.

Robertson does not support the contention that if the policy is "intertwined" with policies of employees, a partner's separate policy becomes covered by ERISA. To the contrary, *Robertson* rejected an argument that the plans in that case were virtually identical and thus were really a single plan. The intertwinement argument "ignores the fact that the plans, however similar, are two separate plans. The plan covering the partners does not pay any benefits to principals, and

the plan covering principals does not pay any benefits to partners." *Robertson,* 798 F.2d at 871. If two virtually identical plans covering different groups of employees are considered separate plans, I see no basis here to hold that there is a single policy where partners paid for their policies individually while the premiums of employees were paid by the firm, partners received different benefits from those negotiated for employees, and employees were required to participate whereas partners were not. That the policies were purchased at the same time and both tasked the firm with minimal administrative duties does not adequately distinguish the case from *Robertson* in my view. *Robertson* is vague as to its facts, but appears to involve two parallel and separate Keogh plans, with nearly identical terms, administered by an accounting partnership on behalf of its partners and its employees.

There is certainly nothing about purchasing policies for employees and partners at the same time that eliminates the bargaining advantage a partner has over an employee. To the contrary, it likely enhances it – the partners, able to control which insurance company their employees are forced to select, gain added negotiating leverage for their own policies. Likewise, common administration of separate and distinct policies for employees and employers does not disadvantage the partner in any way – House as a partner was in a prime position to control the administration of his own policy. *Robertson* reasoned that because partners were situated such that they could exercise control over their own plan, the application of ERISA to partners was unnecessary to protect them from their employers – in other words,

themselves. Even if the policies here were intertwined, that does not change the fact that House as a partner did not need protection under ERISA, and that, under the plain terms of the statute, protection would not extend to his policy unless an employee was covered by it. And here, as *Robertson* noted, "the [policies], however similar, are two separate [policies]." *Id.*

Other Circuits are in accord. The Ninth Circuit has decided this issue and taken the opposite approach from the majority opinion. In *In re Watson,* 161 F.3d 593, 596 n. 4 (9th Cir. 1998), a partner argued that while his plan was separate from that of the employees, it was sufficiently related to the employee's plan as to warrant ERISA coverage for his own plan as well. The court rejected this argument, holding that "even if the plans were created simultaneously or shared other common characteristics, they are independent plans under ERISA." *Id.*; *see also LaVenture v. Prudential Ins. Co. of Amer.,* 237 F.3d 1042, 1046 (9th Cir. 2001) (reiterating *Watson* and adding that "a company may offer more than one benefit plan, one covering only the owner of the business and the other covering the business's employees, and maintain those two plans as independent plans under ERISA").

Similarly, the Eleventh Circuit has held that "non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits." *Kemp v. IBM Corp.,* 109 F.3d 708, 713 (11th Cir. 1997). *Kemp* noted that including a non-ERISA benefit within an ERISA plan does not convert that benefit into one covered by

ERISA. *Id.* Judge Livavdais of the Eastern District of Louisiana, in applying *Robertson* to reach a holding similar to that in *Kemp,* noted the potential consequences of any other interpretation:

> If any court endorsed this view, the insured's choice to participate in a policy other than a group policy would be rendered meaningless; ERISA would become a boundless piece of legislation, sweeping within its scope all claims made under separate policies purchased to provide benefits in addition to those provided by ERISA plans.

St. Martin v. Provident Life & Acc. Ins. Co., Nos. 92-2120, 92-4244, 1993 WL 262708 (E.D. La. July 2, 1993).

Moreover, the cases cited by the majority do not change my view that *Robertson* should guide the Court's analysis here. As the majority points out, *Yates* dealt with situations in which an employee benefit plan covered *both* a working owner, such as a partner, and at least one employee. *See Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* 541 U.S. 1, 124 S. Ct. 1330 (2004). The Supreme Court specifically noted that "if a benefit plan covers *only* working owners, it is not covered by Title I [of ERISA]." *Id.* at 22 n. 6 (citing appellate cases) (emphasis added); *see also id.* at 21, 124 S. Ct. 1330 ("Plans that cover only sole owners or partners . . . fall outside [ERISA's] domain."). Thus, *Yates* does not support the majority's intertwinement argument where, as here, there is a related but separate policy for partners, to which employees do not have access.

Further, in *Wolk,* the parties conceded, without any substantive analysis by the Third Circuit, that the benefit plan at issue was governed by ERISA as it pertained to both partners and employees. *See Wolk v. UNUM Life Ins. of Amer.,* 186 F.3d 352, 355 (3d Cir. 1999). The Third Circuit therefore only addressed whether, as a matter of law, the plaintiff partner, who was designated to receive benefits under the employee benefit plan, qualified as a plan "beneficiary." It was not called upon to decide the issue facing us here. Finally, it is unclear from the facts presented in *Lain v. UNUM Life Ins. Co. of Amer.,* 27 F. Supp. 2d 926 (S.D. Tex. 1998), to what extent the partner's plans were related to the employee's plans. In any event, *Lain* is not binding on this Court and its summary distinguishing of *Robertson* should not influence our analysis.

In sum, the parties have cited no authority supporting the argument that merely because two policies are related to each other, the rationale of *Robertson* does not apply. The authority from our Circuit and others supports the opposite conclusion. Respectfully, I would affirm on this issue under either the clearly erroneous standard or the *de novo* standard of review.

II. Total Disability Definition

I also believe the opinion is in error in reversing the district court's determination that House was totally disabled under the policy. As AUL concedes, ERISA does not preempt Louisiana law regulating the business of insurance, such as Louisiana Revised Statute section 22:230 and state court decisions

limiting and interpreting insurers' definitions of total disability in disability income policies. In concluding that House does not qualify as totally disabled, the majority applies decisions that are distinguishable and inapposite here: *Ellis v. Liberty Assurance Co. of Boston,* 394 F.3d 262, 272 (5th Cir. 2004) and *Provident Life & Accident Ins. Co. v. Sharpless,* 364 F.3d 634, 641 (5th Cir. 2004).

Ellis is inapposite because, in that case, we found that ERISA preempted state-law unfair claims processing and good faith and fair dealing claims, and we applied the ERISA abuse of discretion standard in affirming the plan administrator's denial of total disability income benefits. 394 F.3d at 275-76. As already noted, ERISA preemption does not apply here because Section 22:230 directly regulates the business of insurance and substantially affects the risk-pooling agreements between insurers and insureds. *Sharpless* is inapposite for similar reasons. There, we determined that ERISA preempted the Louisiana statute under which the insured brought her claim, and thus applied contract interpretation principles pursuant to federal common law.

In the present case, Section 22:230, pertinent state court decisions, and the policy definition at issue required the district court to grant House's total disability claim. Section 22:230 provides:

> A. An individual or group disability loss of income policy to provide loss of income protection against total disability may be issued in this state consistent with the definitions and provisions of this Section.

B. *Total disability* may be defined in relation to the inability of the person to perform duties but *shall not be based solely upon an individual's inability to:*

(1) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation"; or

(2) Engage in any training or rehabilitation program.

C. *A general definition of total disability in such a policy shall not be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is, or becomes, qualified by reason of education, training, or experience and which provides him with substantially the same earning capacity as his former earning capacity prior to the start of the disability.*

D. *An insurer may specify the requirement of the complete inability of the individual to perform all of the substantial and material duties of his regular occupation or words of similar import.*

E. An insurer may require care by a physician other than the insured or a member of the insured's family.

(emphasis added).

The Louisiana Civil Code provides the general principles for the interpretation of laws as follows:

"When a law is clear and unambiguous and its application does not lead to absurd consequences, the law shall be applied as written and no further interpretation may be made in search of the intent of the legislature." LA. CIV. CODE ANN. art. 9. "When the language of the law is susceptible of different meanings, it must be interpreted as having the meaning that best conforms to the purpose of the law." LA. CIV. CODE ANN. art. 10. "The words of a law must be given their generally prevailing meaning. Words of art and technical terms must be given their technical meaning when the law involves a technical matter." LA. CIV. CODE ANN. art. 11. "When the words of a law are ambiguous, their meaning must be sought by examining the context in which they occur and the text of the law as a whole." LA. CIV. CODE ANN. art. 12. "Laws on the same subject must be interpreted in reference to each other." LA. CIV. CODE ANN. art. 13.

To properly interpret the statute and the policy a court must also take into account Louisiana's long and unique jurisprudential history of construing such terms in disability income statutes as "total disability," "occupation," "regular occupation," and "all of the substantial and material duties of his regular occupation," in addition to Section 22:230 and its predecessor statutes. As Louisiana legal practitioner-scholars have recognized, this jurisprudence was part of the background upon which the legislature acted in enacting Section 22:230. WILLIAM SHELBY MCKENZIE & H. ALSTON JOHNSON, III, 15 LA. CIVIL LAW TREATISE § 290 (3d ed. 2007).

Under Louisiana cases, total disability has never required proof that an insured is reduced to a state of

abject helplessness. *Laborde v. Employers Life Ins. Co.*, 412 So.2d 1301, 1304 (La. 1982) (citing *Crowe v. Equitable Life Assurance Soc'y of the United States*, 154 So. 52, 54 (La. 1934); *Madison v. Prudential Ins. Co. of America*, 181 So. 871 (La. 1938); *Nomey v. Pacific Mut. Life Ins. Co.*, 33 So.2d 531 (La. 1948); and *Pearson v. Prudential Ins. Co. of America*, 36 So.2d 763 (La. 1948)). In *Johnson v. State Farm Mutual Automobile Insurance Company*, 342 So.2d 664, 667 (La. 1977), the Louisiana Supreme Court relied on this line of cases to interpret an insurance policy defining total disability as the inability to engage in "every duty of his occupation" to mean the inability to "perform the substantial and material part of his occupation in the usual and customary way."

Accordingly, the Louisiana Supreme Court, in *Laborde*, announced that, where an insurance policy expressly purported to adopt the interpretation AUL urges here, the policy would instead be construed to define total disability as "whether he could have performed the substantial and material part of his occupation in the usual and customary way." 412 So.2d at 1304. In fact, the policy definition of total disability in *Laborde* was virtually identical to the one the majority applies: "complete inability of the Insured . . . to perform every duty pertaining to his occupation." In *Johnson*, total disability was similarly defined as the inability to perform "every duty of his occupation." 342 So.2d at 667. Notably, the liberal meaning imposed in place of these nominally strict definitions omitted the word "every."

Subsequent to these cases, the Louisiana Legislature in 1991 enacted Louisiana Revised Statute

section 22:230, a provision plainly intended to limit the ability of insurance companies to adopt overly restrictive definitions of total disability. A leading Louisiana insurance law treatise, WILLIAM SHELBY MCKENZIE & H. ALSTON JOHNSON, III, 15 LA. CIVIL LAW TREATISE § 290 (3d ed. 2007), recently explained how the enactment of Section 22:230 had substantially incorporated the Louisiana courts' jurisprudential total disability standards:

> There is no reason to expect that our courts will abandon the liberal interpretation accorded the concept of disability. Indeed, there may be less reason to do so than there would be in the field of workers' compensation. . . . In the health and accident field, the cost is often borne directly by the insured, who has a much greater argument that he should be entitled to a fair shake on the coverage that he paid for.
>
> Indeed, recent legislative amendments provide that disability definitions cannot be simply whatever an insurer might want them to be. Act 879 of 1990, now appearing as La. R.S. 22:230, establishes a definition of disability beyond which an insurer apparently may not go. Coverage for total disability obviously may be offered in Louisiana, but with certain restrictions.

Id. (footnotes omitted).

With this background in mind, applying the Louisiana Civil Code principles of legislative interpretation, it is evident that the purpose of Section

22:230 is to protect the interests of the insured by placing definite limitations on how insurers may define and apply "total disability" in disability income policies. Paying careful attention to the terms of art as defined by the Louisiana courts in previous cases, construing the statute's provisions in reference to each other, in context, and in conformity with the purpose of the law, the statute in essence provides for: (1) Prohibition of defining total disability in the absolute, unqualified sense: Insurers may not define "total disability" solely as inability to perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation"; or as inability to "[e]ngage in any training or rehabilitation program;" (2) Maximum level of restrictiveness in such definitions: Insurers may define "total disability" in general no more restrictively than as "totally disabled from engaging in any employment or occupation for which [the insured] is, or becomes, qualified by reason of education, training, or experience and which provides him with substantially the same earning capacity as his former earning capacity prior to the start of the disability;" and (3) Specific requirement of insured's complete inability to perform all duties of insured's regular occupation: Insurers "may specify the requirement of the complete inability of the individual to perform all of the substantial and material duties of his regular occupation or words of similar import." Thus, insurers may condition total disability benefits on the insured individual's complete inability to perform all of the important duties of his regular occupation, but to do so requires that the insurer specify this requirement of such complete inability in the policy so that it is called to the insured's attention and agreed to by him.

The disability loss of income policy in this case defines total disability as follows:

> "TOTAL DISABILITY and TOTALLY DISABLED mean that because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation."

The majority misreads the requirements of Section 22:230 and simply disregards the Louisiana jurisprudence defining the terms of art used in the statute. Rather, it mistakenly applies the inapposite decisions in *Ellis* and *Sharpless,* and, in my opinion, incorrectly concludes that the policy definition must be construed to mean that "in order to obtain total disability benefits, House would have to demonstrate that he cannot perform all of the material and substantial duties of his occupation. . . . [T]his means a claimant is totally disabled only if he or she cannot perform each and every material and substantial duty of his or her occupation." Moreover, the majority also declares "the district court's distinction between 'trial lawyer' and 'lawyer' too fine under a common sense interpretation of 'regular occupation.'" Thus, according to the majority, under the policy definition, an attorney would have to be unable to perform each and every material and substantial duty of the legal profession in general in order to qualify for total disability benefits.

I respectfully disagree with the majority's conclusions for several reasons. First, the majority's definition of total disability as inability to perform every duty of lawyers generically is even more

restrictive than the "any and every duty of his occupation" definition prohibited by Section 22:230(B)(1). Use of the term "regular occupation," in Louisiana and in general, means the individual insured's usual and customary means of earning a livelihood, and does not permit the insurer to define total disability at an unreasonably high level of generality so as to offer the insured no real protection in the event he becomes disabled to perform the duties required by his previous regular income-earning activities. As a lawyer, House was still qualified and able to work as a civil servant or governmental attorney, but as a regular occupation that role did not provide him with the earning capacity of his pre-disability high-stress job as an active, experienced actual trial lawyer.

Second, the Louisiana courts have never allowed "total disability" to be defined or applied so restrictively against insured policyholders' interests. *See Laborde*, 412 So.2d at 1304 (rejecting an insurer's advocacy of a definition of total disability similar to that of the proposed opinion in favor of reading the test as "whether he could have performed the substantial and material part of his occupation in the usual and customary way"); *Johnson*, 342 So.2d at 667 (same).

Third, the Louisiana courts' interpretation of total disability policy definitions, as well as that adopted by the statute, is in accord with that of state courts' in general. *See, e.g.*, 46 C.J.S. *Insurance* § 1089:

> Total disability does not mean absolute helplessness, or inability to do anything, or inability to engage in any kind of business

> pertaining to insured's occupation, or absolute lack of earning power. However, an inability to perform some aspects of insured's occupation does not rise to the level of total disability.
>
> Total disability exists when one is wholly disabled from pursuing the usual and customary duties of his employment on which he must depend for a living, or any substantial part of his ordinary duties, or when the injury is such that common care and prudence require insured to desist, and he does in fact desist, from transacting his business.
>
> ***
>
> Generally, when an insurance contract refers to an occupation in promising payments if insured is unable to work, the occupation referred to is the occupation that insured was carrying on at the time that he was injured. When insured lists an occupational description on his application that varies from what he actually does, the court will look to his actual duties, not the application, to determine insured's occupation.

(footnotes omitted) (collecting and citing authorities).

Fourth, as interpreted and applied by the majority, the policy definition would be more restrictive than the maximum level permitted by Section 22:230(C). That is, it would disqualify House for total disability benefits even though in his present law practice capability he does not have substantially the same

earning capacity as his former earning capacity prior to the start of the disability; thus, the majority impermissibly interprets "total disability" more restrictively than permitted by law.

Fifth, AUL in its policy did not take advantage of the opportunity offered by Section 22:230(D) for it to "specify the requirement of complete inability" of House "to perform all of the substantial and material duties of his regular occupation or words of similar import." The policy merely uses a boiler-plate: "TOTAL DISABILITY . . . mean[s] that because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation." Thus, because AUL did not obtain House's agreement to the specific requirement that, to recover total disability benefits, House must have complete inability to perform all of the substantial and material duties of his regular occupation, as authorized by Louisiana Revised Statute 22:230(D), neither AUL nor this Court can define "total disability" contrary to the requirements of Section 22:230(A)-(C).

III. Conclusion

For these reasons, I respectfully submit that the Court should affirm the district court's judgment because that court did not commit: (1) a clear error of fact or an error of law in finding that the partner-employer's disability income policy was separate from the law firm's ERISA-protected and governed employees' group insurance; or (2) an error of law in interpreting and applying state law to the total disability definition in the disability income policy of House, the partner-employer.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

NO. 02-1342

[Filed January 5, 2006]

WALTER RICHARD HOUSE, JR., Plaintiff,	)
v.	)
AMERICAN UNITED LIFE INSURANCE COMPANY, Defendant	)

JUDGMENT ON CROSS MOTIONS FOR SUMMARY JUDGMENT

This action was filed by Plaintiff, **WALTER RICHARD HOUSE, JR.** ("House"), against Defendant, **AMERICAN UNITED LIFE INSURANCE COMPANY** ("AUL"), claiming benefits under a disability insurance policy issued by AUL. The matter is before the Court on multiple sets of cross-motions for summary judgment, which have been the subject of extensive briefing. The Court, having considered the entire record of these proceedings, the evidence submitted by the parties, the applicable law,

the memoranda filed by the parties, and the arguments of counsel, renders the following judgment in accordance with its prior rulings:

IT IS ORDERED, ADJUDGED AND DECREED that there be judgment in favor of House and against AUL for Total Disability/Extended Benefits in the amount of $10,000.00 per month for the 26-month period from October of 2001 through November of 2003, totaling $260,000.00, plus legal interest from the date each payment was due (on the last day of each month) until paid.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that there be judgment in favor of House and against AUL for statutory penalties in the amount of $10,000.00 per month for the 26-month period from October of 2001 through November of 2003, totaling $260,000.00, plus legal interest thereon from the date of this judgment until paid.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that there be judgment in favor of House and against AUL for Total Disability/Extended Benefits for the period from December of 2003 through March of 2005, in the principal amount of $18,327.50, plus legal interest from the date each payment was due (on the last day of each month) until paid.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that there be judgment in favor of House and against AUL for Total Disability/Extended Benefits for the period post-dating March of 2005 in an amount to be determined in accordance with the Court's rulings.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that there be judgment in favor of House and against AUL for Attorney's fees and costs in the amount of $160,965.03 as calculated through February 16, 2005, plus legal interest thereon from the date of this judgment until paid.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the foregoing sums are subject to a credit to AUL for all payments made by it beginning in December 2003.

RENDERED AND SIGNED at New Orleans, Louisiana, on this 20th day of January 2006.

/s/
KURT D. ENGELHARDT
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

NO. 02-1342

[Filed April 20, 2004]

WALTER RICHARD HOUSE, JR.,	)
	)
VERSUS	)
	)
AMERICAN UNITED LIFE INSURANCE COMPANY,	)
	)

ORDER AND REASONS

The Court's Order and Reasons entered on May 27, 2003 (Rec. Doc. No. 43) left open certain issues raised by the Motion for Partial Summary Judgment on the Issues of Benefits, Penalties, and Attorneys' Fees filed by the plaintiff, Walter Richard House, Jr. ("Plaintiff"), on December 20, 2002 (Rec. Doc. No. 26), and the Cross Motion for Partial Summary Judgment on Issue of Benefits filed by the defendant, American United Life Insurance Company ("AUL" or "Defendant"), on January 14, 2003 (Rec. Doc. No. 32). Those remaining issues are presently before the Court. Also to be determined are the parties' subsequently filed cross

motions for summary judgment on the issue of partial disability (Rec. Doc. Nos. 44 and 57).

As stated herein, the Court declines to reconsider its May 27, 2003 ruling that Total Disability benefits payable to Plaintiff are subject to reduction by his earnings from other employment. The Court further concludes that Plaintiff is entitled to receive the greater of the Total Disability and the Partial Disability benefits payable under his insurance policy, but cannot receive both. Additionally, the Court finds that Plaintiff's claim for a penalty and attorney's fees under a R.S. 22:657 is not preempted by ERISA and has merit. Finally, the Court requires additional information from the parties for use in awarding a penalty, attorney's fees, interests, and costs. Accordingly, **IT IS ORDERED** that the parties' cross motions for summary judgment on the issues of benefits, penalties, and attorneys' fees (Rec. Doc. Nos. 26 and 32), are **GRANTED IN PART** and **DENIED IN PART**. **IT IS FURTHER ORDERED** that the parties' cross motions for summary judgment on the issue of partial disability (Rec. Doc. Nos. 44 and 57) are also **GRANTED IN PART** and **DENIED IN PART**.

BACKGROUND

Plaintiff, a former partner in the law firm of House, Kingsmill, & Riess, L.L.C., filed suit against Defendant on May 6, 2002, seeking payment of disability insurance benefits and a penalty and

attorney's fees award under applicable law.[1] Defendant has not paid disability insurance benefits to Plaintiff since September 30, 2001. The parties submitted cross motions for summary judgment in October 2002 (Rec. Doc. Nos. 7 and 9). On December 3, 2002, this Court granted Plaintiff's motion and denied Defendant's motion. In that Order and Reasons, the Court found that Plaintiff is Totally Disabled, as that term is defined by the disability insurance policy issued by Defendant to Plaintiff that became effective on May 1, 2000 (hereinafter, the "House Policy").[2] In evaluating Defendant's preemption argument, the Court further held that it could not determine, as a matter of law, that the House Firm, for purposes of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"), had "established or maintained" an employee welfare benefit plan with the intent to provide disability benefits to Plaintiff, or that the policy issued to Plaintiff was a component of a comprehensive *employee* benefit plan.[3]

On December 20, 2002, and January 14, 2003, respectively, Plaintiff and Defendant filed the cross motions for summary judgment addressed in the Court's May 27, 2003 Order and Reasons. In his

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[1] For a more comprehensive discussion of the factual and procedural background of this matter, see the Court's December 3, 2002 Order and Reasons (Rec. Doc. No. 21) and the May 27, 2003 Order and Reasons (Rec. Doc. No. 43). House, Kingsmill, & Riess, L.L.C. is hereinafter referred to as the "House Firm."

[2] *See* December 3, 2002 Order and Reasons at 24-25.

[3] *Id.* at 38.

motion, Plaintiff sought an award of past and future disability benefits of $10,000 per month, interest, and costs, as well as a penalty and attorney's fees award under La. R.S. 22:657. In opposition to Plaintiff's motion, and in support of its own motion, Defendant argued that the $10,000 maximum monthly benefit payable to Plaintiff under the House Policy must be reduced by other employment income that Plaintiff receives each month. Defendant further urged that Plaintiff's claim for a penalty and attorney's fees award under La. R.S. 22:657 is preempted by ERISA.

Concluding that the cross motions should be granted in part and denied in part, the Court determined that the Total Disability monthly benefits payable to Plaintiff under the House Policy should be reduced by the amount of his monthly earnings from the Louisiana Department of Economic Development.[4] The Court did not decide, at that time, however, whether Plaintiff is entitled to an award of a penalty and attorney's fees under La. R.S. 22:657.[5] Instead, the Court requested additional briefing from the parties regarding ERISA's application to Plaintiff's claim.[6]

Subsequent to filing their supplemental briefs regarding ERISA's application, the parties filed cross motions for summary judgment on the issue of partial disability (Rec. Doc. Nos. 44 and 57). These motions, as

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[4] *See* May 27, 2003 Order and Reasons at 7-8.

[5] *Id.* at 12-14.

[6] *Id.*

well as the questions left open by the Court's May 27, 2003 Order and Reasons, now require resolution.

LAW AND ARGUMENT

Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment is properly granted only "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *See* Fed. R. Civ. P. 56(c). "An issue is material if its resolution could affect the outcome of the action." *Roberts v. Cardinal Servs., Inc.*, 266 F.3d 368, 373 (5th Cir. 2001), *cert. denied,* 535 U.S. 954, 122 S. Ct. 1357 (2002). A factual dispute precludes a grant of summary judgment if the evidence would permit a reasonable trier of fact to find for the nonmoving party. *Smith v. Amedisys,* 298 F.3d 434, 440 (5th Cir. 2002). Any factual controversies must be resolved in favor of the non-moving party. *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir. 1994) (*per curiam*).

The role of summary judgment is to pierce the pleadings and to assess the proof to determine whether there is a genuine need for trial. When the parties present cross motions for summary judgment, as they have here, they essentially agree that there are no genuine issues as to any material fact, and that the matter is ripe for resolution on their motions.

I. Reduction of Total Disability Benefits

In his July 15, 2003 opposition memorandum, Plaintiff asks the Court to reconsider its determination that the maximum monthly benefit payable for Total Disability is to be reduced by the monthly salary Plaintiff began receiving from the Louisiana Department of Economic Development in October 2001.[7] For the reasons stated in its May 27, 2003 Order and Reasons in support of that ruling, the Court declines to do so. As stated therein, the Court does not find the policy language providing for the reduction to be ambiguous. Furthermore, it is not as if *all* disability benefits are lost if the insured earns *any* income from other employment. To the contrary, the benefits are only *reduced* by the amount of the other earnings. And, if an insured is earning 20% or less than his Covered Monthly Earnings in his regular or another occupation, Defendant will not reduce the Monthly Benefit by those earnings.[8] Under these circumstances, the Court does not find the offset provision to be unlawful and therefore unenforceable.

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[7] *See* Plaintiff's July 15, 2003 Memorandum in Opposition to Motion for Partial Summary Judgment on the Issue of Partial Disability (Rec. Doc. No. 58).

[8] *See* House Policy, Section 8, p. 27, which is attached as Exhibit # 2 to the September 22, 2002 Affidavit of Julian Good, Jr., offered in support of Plaintiff's October 4, 2002 motion for partial summary judgment (Rec. Doc. No. 7). *See also* December 3, 2002 Order and Reasons at 3, n. 10, regarding identification of the House Policy.

II. Cross Motions on the Issue of Partial Disability

The House Policy provides the following definitions:

> **Disability and Disabled** mean both Total Disability and Totally Disabled and Partial Disability and Partially Disabled.
>
> * * *
>
> **Total Disability and Totally Disabled** mean that because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation.
>
> **Partial Disability and Partially Disabled** mean that because of Injury or Sickness the Person, while unable to perform every material and substantial duty of his regular occupation on a full-time basis, is:
>
> 1. performing at least one of the material and substantial duties of his regular occupation or another occupation on a part-time or full-time basis; and
>
> 2. is earning less than 80% of his Indexed Pre-Disability Earnings due to that same Injury or Sickness.[9]

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[9] *See* House Policy, Section 2, p. 11

In the May 27, 2003 Order and Reasons, the Court noted that, as defined by the House Policy, an insured could be both Totally Disabled and Partially Disabled.[10] Specifically, an insured could be unable to "perform the material and substantial duties of his regular occupation" on a full-time basis, but be able to earn "less than 80% of his Indexed Pre-Disability Earnings due to that same Injury or Sickness" by "performing at least one of the material and substantial duties of . . . another occupation on a part-time or full-time basis."

Referencing the Court's observation, Plaintiff's motion for summary judgment on the issue of partial disability argues that the House Policy authorizes an award of *both* Total Disability and Partial Disability benefits, as long as the total amount of benefits does not exceed a maximum monthly benefit of $10,000. Although recognizing that Partial Disability benefits can be more generous than Total Disability benefits, Defendant disagrees, for several reasons, that Plaintiff is entitled to receive both Total Disability and Partial Disability benefits.

First, Defendant contends that Plaintiff's evidence is insufficient to establish that he is Totally Disabled or Partially Disabled and, in any event, has thus far been submitted only to support a finding of Total Disability. Second, Defendant maintains that Plaintiff cannot be Partially Disabled and Totally Disabled at the same time, and is not entitled to simultaneous awards for those conditions. Specifically, Defendant

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[10] *See* May 27, 2003 Order and Reasons at 7.

argues that Plaintiff cannot be unable to perform any of the material and substantial duties of a trial attorney while, at the same time, being capable of performing one, but not all, of the duties of a trial attorney. Defendant finally asserts that the doctrines of judicial admission and judicial estoppel preclude a Partial Disability claim because House and his physician have "consistent[ly] and frequent[ly]" asserted Plaintiff's Total Disability throughout this case.

Notwithstanding Defendant's protests, the Court finds that Plaintiff has demonstrated that he is both Totally Disabled and Partially Disabled, as those statuses are defined in the House Policy. As the Court concluded in the December 3, 2002 Order and Reasons, Plaintiff's evidence establishes that he cannot perform every material and substantial duty of his regular occupation, *i.e.*, trial attorney, on a full-time basis. At the same time, however, he is performing at least one of the material and substantial duties of another occupation, that is, serving as Executive Counsel to the Louisiana Department of Economic Development,[11] but

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[11] *See* December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15 ("I have not returned to the practice of trial law. I have . . . obtained other gainful employment. As you know, I have practiced business, international, and energy law since March, 2001 and became Executive Counsel of the Louisiana Department of Economic Development on October 15, 2001."); *see also* January 14, 2003 Brief in Support of Defendant's Cross Motion for Partial Summary Judgment on Benefits and Opposition to Plaintiff's Motion for Summary Judgment on Issues of Benefits, Penalties, and Attorneys' Fees (hereinafter "Defendant's January 14, 2003 Brief")

because of the same Injury or Sickness that prevents him from performing every material and substantial duty of his regular occupation, is earning less than 80% of his Indexed Pre-Disability Earnings.[12]

(Rec. Doc. No. 32) at 4, 21-22 (seeking reduction in benefits to Plaintiff equal to salary earned as Executive Counsel to the Louisiana Department of Economic Development and defending its denial of Plaintiff's claim based, in part, on that employment); October 29, 2002 Memorandum in Support of Defendant's Cross Motion for Summary Judgment and Opposition to Plaintiff's Motion for Partial Summary Judgment (hereinafter "Defendant's October 29, 2002 Memorandum") (Rec. Doc. No. 9) at 18 (recognizing Plaintiff's present employment as Executive Counsel to the Louisiana Department of Economic Development); September 20, 2002 Affidavit of Walter Richard House, Jr. at ¶ 21 (referencing Executive Counsel position), submitted with Plaintiff's October 4, 2002 Memorandum in Support of Motion for Partial Summary Judgment on the Issue of Walter Richard House, Jr.'s Disability (hereinafter "Plaintiff's October 4, 2002 Memorandum) (Rec. Doc. No. 7).

[12] *See, e.g.*, February 23, 2001 Claim Summary by Linda Cross of AUL, AUL000312-317 (Plaintiff must earn less than $13,333.34 per month to meet definition of Partially Disabled); March 2, 2001 Correspondence from Linda Cross of AUL to Plaintiff, AUL 000159-63 (informing Plaintiff that he was considered Partially Disabled from November 16, 2000 until [he] ceased work activity in 2001"); March 26, 2001 Correspondence from Linda Cross of AUL to Plaintiff (asserting that Plaintiff's earnings were less than 80% after January 1, 2001); October 12, 2001 Statement of Income, AUL000039-40 (showing Plaintiff's income as an attorney for September 2001 to be $2164.05); December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15 (Plaintiff's monthly income is approximately 45% of Covered Monthly Income); April 2, 2002 Correspondence from Felix R. Weill to Kimberly Shaw of AUL, AUL000004-7 (Plaintiff's

The Court further disagrees that its determination that Plaintiff is Totally Disabled means that Plaintiff cannot also be Partially Disabled. *Cf.* 12 LEE R. RUSS & THOMAS F. SEGALIA, COUCH ON INSURANCE § 182:8 at 182-14 ("In the absence of a provision to the contrary, the insured has the freedom of selecting the remedy alternative which is most favorable to him or her.") In arguing that Plaintiff cannot satisfy the definition of Totally Disabled, but still be able to perform at least one of the material and substantial duty of his *regular* occupation, Defendant ignores that the definition of Partially Disabled alternatively contemplates performance of at least one material and substantial duty of *another* occupation. As explained above, the latter situation is that which is present here.

Nevertheless, the Court does agree with Defendant that its policy does not contemplate an insured receiving Total Disability benefits *and* Partial Disability benefits. Regarding this issue, the Court notes that the House Policy states that when Defendant "receives proof that a Person is Disabled . . . [Defendant] will pay the Person *a* Monthly Benefit."[13]

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income now about 45% of his Indexed Pre-Disability Income); *see also* Plaintiff's May 30, 2003 Memorandum in Support of Motion for Partial Summary Judgment on the Issue of Partial Disability (Rec.Doc. No. 44) at 2, n. 4 (calculations demonstrating earnings of less than 80%); May 30, 2003 Statement of Material Facts on the Issue of Partial Disability as to Which Walter Richard House, Jr. Contends There is No Genuine Issue for Trial (Rec. Doc. No. 44) at ¶ 3 (monthly average earnings for 1997-1999 were $21,970).

[13] *See* House Policy, Section 8, p. 22 (emphasis added).

As stated above, the term "Disabled" means both Total Disability and Partial Disability.[14] The Monthly Benefit is the amount of benefit paid each month to the insured, and is defined as the Gross Monthly Benefit, reduced by Other Income Benefits.[15] Gross Monthly Benefit is the amount of benefit payable on a monthly basis, prior to any reductions.[16] Based on these policy provisions, the Court concludes that the House Policy contemplates the payment of only one Monthly Benefit regardless of whether Plaintiff is Totally or Partially Disabled or both, and regardless of any offsets. Accordingly, Plaintiff must choose whether he wishes to receive Partial Disability benefits or Total Disability benefits. He cannot receive benefits for both conditions.

Lastly, the Court does not find that the doctrines of judicial admission and/or judicial estoppel preclude Plaintiff from seeking to recover Partial Disability benefits, if he so chooses, at this stage of the proceeding. Indeed, it does not find that either doctrine applies to this case.

Factual assertions in pleadings and pretrial orders are considered to be judicial admissions conclusively binding on the party making them. *White v. ARCO/Polymers, Inc.*, 720 F.2d 1391 (5th Cir. 1983). Such statements, however, must be "deliberate, clear, and unequivocal." *In re Corland Corp.*, 967 F.2d 1069,

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[14] *Id.*, Section 2, p. 6.

[15] *Id.*, Section 2, pp. 3-8.

[16] *Id.*, Section 2, p. 7.

1072 (5th Cir. 1992). Here, however, Plaintiff has never asserted that he is only Totally Disabled or disclaimed any suggestion that he satisfies the policy definition of Partially Disabled. In his complaint, Plaintiff asserted both Total Disability and Partial Disability, albeit in the alternative.[17] Similarly, though Plaintiff previously did seek summary judgment only on the issue of his Total Disability, he has repeatedly emphasized Defendant's failure to pay either Total or Partial Disability benefits, since September 30, 2001, in his supporting memoranda.[18] Further, there has been no pretrial order entered in this proceeding. Finally, even if Plaintiff's assertions of Total Disability are deemed to be an admission that he can perform none of the material and substantial duties of a trial attorney, that admission does not mean that he cannot

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[17] *See* May 6, 2002 Complaint (Rec. Doc. No. 1) at ¶ 6 and Prayer.

[18] *See, e.g.*, Plaintiff's October 4, 2002 Memorandum at 13 (Defendant's November 20, 2001 denial letter made no mention of Partial Disability under the policy); Plaintiff's November 5, 2002 Memorandum in Opposition to Defendant's Motion for Partial Summary Judgment and in Further Support of Plaintiff's Motion (hereinafter "Plaintiff's November 5, 2002 Memorandum") (Rec. Doc. No. 12) at 19-20 ("AUL was arbitrary and capricious when it failed to consider whether . . . [Plaintiff] might be eligible [for benefits] under Partial Disability"); Plaintiff's December 20, 2002 Memorandum in Support of Motion for Partial Summary Judgment on the Issues of Benefits, Penalties, and Attorneys' Fees (Rec. Doc. No. 26) at 4, n. 9 ("AUL completely ignored the issue" of Partial Disability); *see also* December 3, 2002 Order and Reasons at 12, n. 32 (noting that Defendant has not attempted to meet Plaintiff's alternative argument that he is and was entitled to Partial Disability benefits during all phases of the benefit determination).

perform the material and substantial duties of an occupation other than his regular occupation.

The doctrine of judicial estoppel "prevents a party from asserting a position in a legal proceeding that is contrary to a position previously taken [by that party] in the same or a prior proceeding."*Hall v. GE Plastic Pacific PTE Ltd.*, 327 F.3d 391, 396 (5th Cir. 2003) (quoting *Ergo Science, Inc. v. Martin*, 73 F.3d 595, 598 (5th Cir. 1996)). The purpose of the doctrine is to protect the integrity of the judicial proceeding. *Newfield Exploration Co. v. Applied Drilling Tech., Inc.*, 2003 WL 23253, *3 (E.D. La. 1/02/03) (Africk, J.) (quoting *In re Coastal Plains, Inc.*., 179 F.3d 197, 205 (5th Cir. 1999) (internal citations omitted)). Thus, a party is not allowed to advance one argument and then "for convenience or gamesmanship after that argument has served its purposes, advance a different and inconsistent argument." *Id.* (quoting *Hotard v. State Farm Fire & Cas. Co.*, 286 F.3d 814, 818 (5th Cir. 2002)).

For a party to be judicially estopped from taking a particular position, the party's later position must be clearly inconsistent with the earlier position. In addition, that party must have convinced the court to accept its earlier position such that judicial acceptance of the later position would "create 'the perception that either the first or second court was misled.'" *Id.* (quoting *New Hampshire v. Maine*, 532 U.S. 742, 750-51, 121 S. Ct. 1808, 1815 (2001) (internal citations omitted)). A court should also consider "whether 'the party seeking to assert an inconsistent position would derive an unfair advantage or impose an unfair detriment on the opposing party if not estopped.'" *Id.*

(quoting *New Hampshire v. Maine*, 532 U.S. 742, 751, 121 S. Ct. 1808, 1815 (2001) (internal citations omitted)).

As previously explained, the definitions that Defendant chose to provide in the House Policy are what allow Plaintiff to satisfy both disability statuses. Thus, Plaintiff's claims of Total Disability and Partial Disability are not truly inconsistent, even though the Court has determined that Plaintiff may not actually recover both Total Disability and Partial Disability benefits. Further, though the Court did "accept" Plaintiff's Total Disability argument in granting his October 4, 2002 motion for partial summary judgment, that acceptance does not preclude the Court's consideration of Plaintiff's Partial Disability claim, particularly since Plaintiff pled Partial Disability in his complaint, final judgment has not been entered, and the ordinary course of this proceeding has not been irrevocably altered because of the Court's December 3, 2002 or May 27, 2003 rulings. It is not as if, for example, the Court's earlier ruling dismissed a party or a claim that Plaintiff's Partial Disability claim would require to be brought back into the case. Finally, and significantly, Plaintiff's decision to press his claim for Partial Disability benefits at this juncture of the proceeding does not lead the Court to believe that it previously was misled, that Plaintiff is trying to "play fast and loose" with the legal process, or that Defendant has been prejudiced in any way. Defendant's assertions on this issue, moreover, do not justify a conclusion that Plaintiff will derive an unfair advantage or impose an unfair detriment on Defendant. Indeed, Defendant has not even contended that it will be prejudiced, much less explained how it

will be prejudiced, if Plaintiff is allowed to pursue his Partial Disability claim. The Court certainly is not aware that Defendant has paid any Total Disability benefits as a result of the December 3, 2002 Order and Reasons or May 27, 2003 Order and Reasons.

III. Penalty and Attorney's Fees Under La. R.S. 22:657

La. R.S. 22:657 provides for an award of a penalty and attorney's fees if an insurer fails to pay benefits under a health or accident insurance contract within thirty days, "unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist." *See* La. R.S. 22:657; *Cramer v. Association Life Ins. Co.*, 569 So.2d 533, 538 (La. 1990), *cert. denied,* 499 U.S. 938, 111 S. Ct. 1391 (1991). The statute applies to claims for disability insurance benefits. *See, e.g., Kottle v. Provident Life and Accid. Ins. Co.*, 775 So.2d 64 (La. Ct. App. 2 Cir. 2000), *writ denied,* 790 So.2d 635 (La. 2001); *Johnson v. Trustmark Ins. Co.*, 771 So.2d 307 (La. Ct. App. 2 Cir. 2000), *writ denied,* 786 So.2d 101 (La. 2001); *Bowers v. Sun Life Assur. Co. of Canada,* 768 So.2d 37 (La. Ct. App. 3 Cir. 1999), *writ denied,* 771 So.2d 82 (La. 2001). Plaintiff contends that Defendant's refusal to pay him any disability benefits after September 30, 2001, is arbitrary and capricious; thus, he is entitled a penalty and attorney's fee award under La. R.S. 22:657.

As the Court explained in the May 27, 2003 Order and Reasons, however, the Court must first determine whether ERISA applies to Plaintiff's claim. If governed by ERISA, Plaintiff's state law claims under La. R.S. 22:657 are preempted. *See Hicks v. CNA Ins. Co.*, 4 F.

Supp. 2d 576, 579 (E.D. La. 1998); *Coles v. Metropolitan Life Ins. Co.*, 837 F.Supp. 764, 768 (M.D. La. 1993); *see also Cramer*, 569 So.2d at 538.

A. ERISA Preemption of La. R.S. 22:657

ERISA's application turns on whether Plaintiff has sought benefits under an "employee welfare benefit plan" as that term is defined by ERISA. *See Meredith v. Time Ins. Co.*, 980 F.2d 352, 353 (5th Cir. 1993) (summary calendar). This is a question of fact. *Id.* An employee welfare benefit plan is defined by ERISA as:

> any plan, fund, or program which was . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, [or] disability. . . .

29 U.S.C. § 1002(1). Under the Fifth Circuit's jurisprudence, a particular insurance arrangement qualifies as an employee welfare benefit plan under ERISA if: (1) it is a "plan";[19] (2) it does not fall within the safe-harbor provision established by the Department of Labor;[20] and (3) it was established or

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[19] A "plan" exists if "a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." *Meredith*, 980 F.2d at 355.

[20] If the relevant plan satisfies all of the requirements of the safe-harbor provision, it is exempt from ERISA's coverage. *See Meredith*, 980 F.2d at 355. The safe-harbor provision, 29 C.F.R.

maintained by an employer with the intent to benefit employees. *See Lain v. UNUM Life Ins. Co.*, 27 F. Supp.2d 926, 930 (S.D. Tex. 1998) (citing *Meredith*, 980 F.2d at 355), *aff'd*, 279 F.3d 337 (5th Cir. 2002)). If any of these three prongs is answered negatively, the insurance arrangement is not an ERISA plan. *Meredith*, 980 F.2d at 355.

Here, the parties do not agree on what the alleged "plan" is. Specifically, the parties dispute whether (1) the House Policy itself, (2) the policies made available to only partner attorneys of the House Firm, or (3) all of the disability insurance policies obtained by the House Firm for the benefit of the firm's employees, non-partner attorneys, and partners, is "the plan." Plaintiff argues that the relevant plan is either the House Policy itself or the disability pol[illegible]ies made available only to partner attorneys of the House Firm. Defendant maintains that the package of disability insurance policies provided by it to the House Firm

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§ 2510.3-1(j), applies to "a group or group-type insurance program offered by an insurer to employees . . ." that meets the following criteria:

(1) No contributions are made by an employer;

(2) Participation in the program is completely voluntary for employees;

(3) The sole functions of the employer with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees, to collect premiums through payroll deduction, and to remit them to the insurer; and

(4) The employer receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered with payroll deductions.

employees, nonpartner attorneys, and partner attorneys is the relevant plan, and that the House Policy is only one component of that plan.

Given the importance of this issue, and because of certain questions raised in the materials submitted by the parties, the May 27, 2003 Order and Reasons directed the parties to provide additional submissions regarding this issue. Having reviewed the parties' previous and supplemental submissions in the context of pertinent case law, the Court now concludes that the relevant plan is the House Policy itself, or the AUL disability policies made available to only the partner attorneys of the House Firm. Because those policies have never covered any House Firm employees, the policies were not "established or maintained by an employer with an intent to benefit employees," and, therefore, are not covered by ERISA. *See Meredith*, 980 F.2d at 356-58 (a plan without employees is not regulated by ERISA).

In reaching this conclusion, the Court is guided by the Fifth Circuit's decision in *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1986), *cert. denied*, 479 U.S. 1089, 107 S. Ct. 1396 (1987), the Eleventh Circuit's decision in *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1105-06 (11th Cir. 1999), and Judge Livaudais' decision in *St. Martin v. Provident Life & Accident*, 1993 WL 262708 (E.D. La.). In *Robertson*, the Fifth Circuit held that two retirement plans, one covering the partner-owners of a business and the other covering employees, were two separate plans for purposes of ERISA. *Id.* at 871. Rejecting the argument that the two plans were really one plan

because they were "nearly identical," the Court of Appeals explained:

> Robertson's argument, however, misses the point. His argument ignores the fact that the plans, however similar, are two separate plans. The plan covering the partners does not pay benefits to principals, and the plan covering principals does not pay any benefits to partners. Since the plans are separate, the plan covering partners covers only partners, and the district court correctly ruled that the plan does not cover employees other than partners.

Id. at 871-72 (finding that the Grant plan covered only partners and affirming the district court's ruling holding ERISA inapplicable to plans covering only partners).

In *Slamen,* the Eleventh Circuit held that a disability insurance policy covering only a dentist was not an ERISA plan, even though the dentist also had in place a policy providing health and life insurance coverage to himself and his employees. 166 F.3d at 1105. Explaining its decision, the Court of Appeal emphasized that there was no evidence showing that the insurance polices were "related." *Id.* at 1105-06. Although the Court did not elaborate on what would make the policies "related," it pointed out that "the two policies were purchased at different times, from different insurers, and for different purposes." *Id.* at 1105.

Finally, in the *St. Martin* case, Guardian asserted that the St. Martin firm established and funded an

ERISA plan through the purchase of several insurance policies, including an individual professional disability policy for Michael St. Martin that supplemented the coverage provided him by the firm's group policy. *Id.* at *1. The Court first rejected the argument that ERISA governed St. Martin's claim for benefits under the individual policy simply because it supplemented the benefits he received under the group ERISA plan. *Id.* at 2. Additionally, citing *Robertson,* the court concluded that, because St. Martin's individual disability policy provided benefits only to St. Martin, who was not an employee, the policy was not governed by ERISA. *Id.* Finally, the court rejected Guardian's contention that the individual disability policy was a component of the firm's ERISA plan because St. Martin had indicated on his application for the disability policy that the firm would pay 100% of the policy premiums. *Id.* at 3. The court noted that the evidence showed the contrary, *i.e.,* that the premiums were taxed as income to St. Martin in 1990 and 1991. *Id.*

Here, it is true that the disability insurance coverage obtained for Plaintiff and the other partner attorneys, as well as the non-partner attorneys and other employees of the House Firm, was secured by the House Firm at the same time, from the same insurer, for the same purpose, and through the use of single application, *i.e.,* the Subscription Agreement.[21] In

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[21] *See* Group Life Application and Long Term Disability/Short Term Disability Subscription Agreement for 10+ Lives (hereinafter, the "Subscription Agreement"), AUL000373-382, KR0527-537. Documents bearing "AUL" Bates numbers are

addition, *some* degree of "administration" was provided by the House Firm with respect to all of the policies.[22] Based on these facts, the Court agrees that these facts technically create a relationship between the various policies.

At the same time, the Court does not agree that this relationship, when considered in light of other evidence, is sufficient to establish that the House Plan is, or is a part of, an ERISA plan. To the contrary, the Court finds that, as in *Robinson,* the disability insurance plans obtained for partner attorneys of the House Firm were separate from the group coverage provided by the firm to nonpartner attorneys and employees, and thus are not covered by ERISA. Similarly, the Court finds that the coverage provided to Plaintiff is analogous to that which the individual policy provided to the plaintiff in the *St. Martin* case. In other words, facts demonstrating the separate nature of the disability policies issued to partners of

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documents from Defendant's claim file that were produced by Defendant. Plaintiff submitted the "AUL" documents with Plaintiff's October 4, 2002 Memorandum. Documents bearing "KR" Bates numbers were produced by the Kingsmill, Riess firm (the successor to the House Firm) in response to a subpoena issued by Defendant. Plaintiff submitted the "KR" documents with his January 28, 2003 Memorandum in Opposition to AUL's Motion for Partial Summary Judgment on the Issue of Benefits (hereinafter "Plaintiff's January 28, 2003 Memorandum") (Rec. Doc. No. 35).

[22] The parties disagree on the exact nature and extent of the House Firm's administration of the House Policy and the other disability insurance policies.

the House Firm overcome any suggestion, at least in this case, that a relationship between the policies, created by the circumstances of the insurance placement and/or any post-issuance administration by the House Firm and/or Defendant, causes ERISA to apply to those policies.

The Court reaches this conclusion for a number of reasons. First, the Court is heavily persuaded by the fact that the House Policy pays benefits only to Plaintiff, who was a partner of the House Firm. Neither it nor the policies issued to the other partners provide benefits to the nonpartner attorneys or the other employees of the firm.[23] Indeed, Plaintiff is the only insured listed on the policy issued to him.[24] Likewise, the benefits payable under the policies

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[23] The Subscription Agreement submitted by the House Firm identified three classes of insureds and the benefits payable to each. *See* Subscription Agreement, AUL000373-383, KR0527-37. Ultimately, Defendant provided separate policies for the three classes of insureds, which policies were effective on May 1, 2000. *See* September 22, 2002 Affidavit of Julian Good, Jr., ¶ 2.4, submitted with Plaintiff's October 4, 2002 Memorandum, and Exhibits # 2-4 to that affidavit (copy of policies effective on May 1, 2000). One policy covers partner attorneys. *See* AUL000384-422, KR0383-420 (Class 1). Another covers nonpartner attorneys. *See* AUL000423-61, KR0421-58 (Class 2). The third covers other House Firm employees. *See* AUL000462-500, KR0459-96 (Class 3).

[24] *See* House Policy, pp. 00-1. The Certificate of Insurance for the policy issued to House states: "Change Effective Date, Member: 5/1/00 Group: Does Not Apply." *See* House Policy, p. 1.

issued to the House Firm employees are not available to partners.[25]

Second, Plaintiff, not the House Firm, personally paid 100% of the premiums for his policy.[26] Significantly, however, it is undisputed that the House Firm paid 100% of the premiums for the policies covering the non-partner attorneys and the other firm employees.[27] Third, Plaintiff's and the other partners' participation in the disability coverage provided by Defendant was purely voluntary.[28] Eligible employees,

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[25] *See* Note 23.

[26] *See* Subscription Agreement, AUL000373-383, KR0527-37; *see also* June 16, 2003 Defendant's Brief on the Application of ERISA in Response to May 27, 2003 Order and Reasons (Rec. Doc. No. 49) at 5, 8; January 27, 2003 Plaintiff's Answers to the Statement of Material Facts as to Which Defendant Contends There is No Genuine Issue Requiring Trial (Rec. Doc. No. 35) ¶ 31; January 25, 2003 Third Affidavit of Walter Richard House, Jr. (Rec. Doc. No. 35) ¶ 5. Defendant makes much of the fact that the Subscription Agreement obligated the House Firm to remit all premiums, including those for the partners' policies. That the House Firm agreed to collect and transmit the premiums to Defendant, however, is of little significance. It is undisputed that the premiums were charged against each partner's firm drawing account.

[27] *See* Note 26; *see also* November 15, 2002 Defendant's Post-Hearing Brief (Rec. Doc. No. 16) at 4-5 (House Firm agreed to pay 100% of the premiums for Classes 2 and 3).

[28] *See* Subscription Agreement, AUL000379, 383, KR0533,36; Plaintiff's December 20, 2002 Statement of Material Facts on the Issues of Benefits, Penalties, and Attorneys' Fees as to Which

including the non-partner attorneys, however, were automatically covered because the House Firm paid 100% of their premiums.[29] Fourth, certain of the policy provisions differed for partners. For instance, Basic Monthly Earnings for partners is defined as the monthly average of the amount shown as net earnings from the Schedule K-1's, a schedule for partners for the three (3) most recent years.[30] Basic Monthly Earnings for employees, including nonpartner attorneys, is defined as the person's current monthly pay before taxes based on a maximum of a 40-hour week.[31] In addition, the definition of Total Disability for the partner and nonpartner attorneys differs from that applicable to other employees. For attorneys, that term means "because of Injury or Sickness the Person

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Walter Richard House, Jr. Contends There is No Genuine Issue (Rec. Doc. No. 26) at ¶ 10 (Plaintiff had the choice of whether or not purchase the House Policy) (citing Second Affidavit of Walter Richard House, Jr., dated December 18, 2002, ¶ 3)); Defendant's Long Term Disability Proposal, Schedule of Benefits and Rates, AUL001591 (indicating Class 1 coverage to be contributory with 90-100% participation), which was submitted with Plaintiff's January 28, 2003 Memorandum.

[29] *See* Subscription Agreement, AUL000379, 383, KR0533, 536; Defendant's Long Term Disability Proposal, Schedule of Benefits and Rates, AUL001591 (indicating Class 2 & 3 coverage to be noncontributory and with 100% participation).

[30] *See* Subscription Agreement, AUL000379,383, KR0533,36; *see also* House Policy, Section 2, p. 5; Class 1 Policy, KR 0388, AUL000389.

[31] *See* Class 2 Policy, KR0426, AUL000428; Class 3 Policy, KR0464, AUL000467.

cannot perform the material and substantial duties of his regular occupation."[32] For the other employees, one is Totally Disabled, after benefits have been paid for 36 months, only if he or she "cannot perform the material and substantial duties of any gainful occupation for which the Person is reasonably fitted by training, education, or experience.[33]

Considering the specific facts and circumstances of this case and the relevant jurisprudence, the Court determines that the House Policy does not constitute and is not part of an ERISA plan. Accordingly, ERISA does not preempt the application of La. R.S. 22:657 to this matter. *Cf. Page v. UNUM Life Ins. Co.*, 2000 WL 748154, *2 (N.D. Tex.) (concluding preemption determination turned on whether single policy or group of policies should be evaluated together or separately).

B. Application of La. R.S. 22:657

As previously stated, La. R.S. 22:657 provides for an award of a penalty and attorney's fees if an insurer fails to pay benefits under a health or accident insurance contract within thirty days, "unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist." *See* La. R.S. 22:657. The statute "was enacted to effect a speedy collection of just claims without diminution and

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[32] *See* House Policy, Section 2, p. 11; Class 1 Policy, KR0394, AUL000395; Class 2 Policy, KR0432, AUL000434.

[33] *See* Class 3 Policy, KR 0470, AUL000473.

without unnecessary delay and expense." *Crawford v. Blue Cross Blue Shield of Louisiana,* 770 So.2d 507, 517 (La. Ct. App. 1 Cir. 2000) (citing *Lopez v. Blue Cross of Louisiana,* 397 So.2d 1343, 1345 (La. 1981)), *writ denied,* 786 So.2d 98 (La. 2001).

The absence of "just and reasonable grounds for failing to pay" has been equated with a finding of "arbitrary and capricious" conduct. *Crawford,* 770 So.2d at 515; *see also Houston v. Blue Cross and Blue Shield of Louisiana,* 843 So.2d 542, 548 (La. Ct. App. 2 Cir.) (La. R.S. 22:657 penalty should not be assessed unless refusal to pay is clearly arbitrary and capricious), *writ denied,* 853 So.2d 641 (La. 2003). "An insurer's actions are 'arbitrary and capricious' when its willful refusal of a claim is not based on a good faith defense . . . or is unreasonable or without probable cause[.]" *Wallace v. State Farm Mutual Auto. Ins. Co.,* 821 So.2d 704, 710 (La. Ct. App. 2d Cir. 2002). This determination is a question of fact to be decided on the facts and circumstances of each case. *Houston,* 843 So.2d at 548; *Crawford,* 770 So.2d at 515.

An insurer receiving notice that a claim has been made under its policy has a duty to investigate the claim. *Houston,* 843 So.2d at 548. An insurer resisting its contractual obligation based on a supposed defense, which a reasonable investigation would have disproved, "'acts at its peril and renders itself liable for statutory penalties and attorney's fees.'" *Crawford,* 770 So.2d at 518 (quoting *Savarino v. Blue Cross and Blue Shield of Louisiana, Inc.,* 730 So.2d 1083, 1090 (La. Ct. App. 1 Cir. 1999)). Furthermore, "[i]f correspondence is insufficient for submission of a claim, it is incumbent on the insurer to respond with proper

instructions on proper submission of the claim." *Houston,* 843 So.2d at 550.

1. Total Disability Benefits

In the section of the December 3, 2002 Order and Reasons granting Plaintiff's motion for partial summary judgment on the issue of Total Disability, the Court stated: "[regardless of whether a *de novo* or arbitrary and capricious standard is used, a record this strong, including the uncontroverted opinion of House's treating cardiologist that he is presently disabled from his regular occupation (trial attorney), mandates a ruling in favor of the plaintiff."[34] The Court's conclusion on that issue has not changed. For that reason, the Court refers the parties to the factual statements and analysis in the December 3, 2002 Order and Reasons, as that explanation sufficiently demonstrates why a penalty and an award attorney's fees should be imposed against Defendant. Notwithstanding this reference, the Court writes here for additional emphasis.

In asserting that its refusal to pay any disability benefits to Plaintiff after September 30, 2001, was reasonable, Defendant argues Dr. Cook's opinion that Plaintiff is totally disabled from litigation, but not other areas of law, is not supported by objective

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[34] *See* December 3, 2002 Order and Reasons (Rec. Doc. No. 21) at 24.

medical evidence.[35] It further objects to Plaintiff's characterization of his regular occupation (at the time he became disabled in October 2000) as being a "trial attorney," rather than simply "'an attorney."[36] Maintaining that Plaintiff makes an unsupported and artificial distinction between his current employment and his occupation while at that House Firm, Defendant contends: "House's attempts to create sub-specialties of the legal profession and complain of his inability to practice within one of them should be unavailing."[37] Defendant finally contends that, even if Plaintiff's former occupation was a "trial attorney," Plaintiff has not demonstrated that the "material and substantial duties" of his present occupation are any less stressful that those of a trial attorney.[38]

a. Dr. Cook's Opinion

Considering Plaintiff's post-bypass health condition, medical history (including the myocardial infarction he suffered in October 1999), age, and his own understanding of the stress inherent with Plaintiff's litigation practice, Dr. Cook, a board

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[35] *See* Defendant's October 29, 2002 Memorandum at 8-9, 15, and 18; Defendant's January 14, 2003 Brief at 21.

[36] *See* Defendant's October 29, 2002 Memorandum at 16.

[37] *Id.*

[38] *Id.* at 17-19; *see also* Defendant's January 14, 2003 Brief at 21 ("Mr. House reported that he was working in an apparently responsible position; there was no basis for AUL to conclude Mr. House was less 'stressed' in that position than in trial work").

certified cardiologist and, since the 1980's, Plaintiff's treating physician, concluded that Plaintiff is totally disabled from his occupation as a trial attorney. He informed Defendant of this determination in the Attending Physician's Statement provided with Plaintiff's initial application for benefits, explaining that Plaintiff "is able to engage in only limited stress situations and engage in only limited interpersonal relations," and is totally disabled from his job, but not from other work.[39] He reaffirmed this opinion on numerous occasions throughout 2001, emphasizing that Plaintiff was restricted from a litigation practice.[40]

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[39] *See* November 2000 Attending Physician Statement, AUL000181.

[40] *See* January 24, 2001 Correspondence from Dr. Cook to Defendant, AUL000158 (Mr. House . . . has been totally and permanently disabled."); February 7, 2001 Office Visit Note, AUL000729 ("Cannot practice litigation; Total and Permanent Disability as set forth in letter of 1-24-01."); March 1, 2001 Attending Physician's Statement, AUL000790 ("cannot practice litigation, totally permanently disabled"); April 5, 2001 File Memo by AUL Medical Consultant Leslie Walls, RN, AUL000288 (Dr. Cook called . . . advises that [Plaintiff] can still be a lawyer, but he cannot perform litigation); July 31, 2001 Physician's Supplemental Statement, AUL000250 (patient disabled from his job but not other work; incapable of performing litigation practice); November 1, 2001 Attending Physician Statement, AUL000026 ("no litigation practice" for patient). Dr. Cook's evaluation of Plaintiff's condition had not changed as of September 19, 2002. At that time, he explained:

> 3.6 It is my opinion that the level of stress Mr. House encountered in his practice as a trial attorney . . .

Plaintiff further reiterated Dr. Cook's assessment to Defendant on numerous occasions, explaining that Dr. Cook had advised that his litigation practice was a substantial factor in his heart disease.[41] In fact, in

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> significantly contributed to his acute myocardial infarction in October 1999 and to his coronary artery disease that required the quadruple bypass surgery in October, 2000. Indeed, I am familiar with the stressors which are inherent in the work of trial lawyers as my father also practiced in this area. For these reasons, I have deemed Walter Richard House, Jr. to be totally and permanently disabled from practicing law as a trial attorney, and he continues to be disabled from doing his work.
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> * * *
>
> **3.9** I believe that withdrawing from the practice of trial law has been the major element in his continued recovery, and I would not recommend that he return to trial practice. His returning to the stress of trial work, against my instructions, could cause severe medical repercussions, including death.

See September 19, 2002 Affidavit of John R. Cook, M.D., which Plaintiff submitted with his October 4, 2002 motion for partial summary judgment (Rec. Doc. No. 7).

[41] *See, e.g.*, November 30, 2000 Correspondence from Plaintiff to Defendant and Group Disability Application, AUL000172-74, 179-84 (because of physical condition cardiologist has recommended change in legal practice from trial law); March 25, 2001 Training Education and Experience Form submitted by Plaintiff, AUL000148-49 (Plaintiff left House Firm because he "could not practice law as before heart disease"); April 9, 2001 Correspondence from Plaintiff to Linda Cross of AUL, AUL00012 ("Dr. Cook has advised AUL that in his opinion as a board

one of its briefs, Defendant acknowledges that "House actively pursued his claim with AUL both through frequent phone calls and no less than twenty letters, all the while claiming total disability."[42]

Although Defendant has refused to accept Dr. Cook's assessment of Plaintiff's medical condition, it has never—not before and not since Plaintiff filed suit and sought summary judgment—provided a countervailing medical opinion or produced other contradictory medical evidence.[43] This fact is fatal to

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certified cardiologist and internist, the practice of trial law is a substantial factor in my heart disease and I am therefore disabled from pursuing to substantial and material duties of my occupation of over 25 years"); May 2, 2001 Correspondence from Plaintiff to Linda Cross of AUL, AUL000110 (same); May 10, 2001 Correspondence from Plaintiff to Linda Cross to AUL, AUL000107-09 (same); December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15 (cardiologist has reported that considering history and quadruple bypass he recommends that Plaintiff discontinue practice of trial law). Dr. Cook confirmed Plaintiff's statements in his September 19, 2002 affidavit. *See* Note 40.

[42] *See* July 8, 2003 Memorandum in Support of Defendant's Cross Motion for Partial Summary Judgment (Rec. Doc. No. 57) at 5.

[43] In Defendant's October 29, 2002 Memorandum, Defendant references the statement in the records of Dr. Bethea, the cardiothoracic surgeon who performed Plaintiff's bypass surgery, that Plaintiff could return to "full activity and return to see me [as needed]." *See* November 21, 2000 Office Notes, AUL000563. The Court does not find Defendant to have shown this statement to have the significance that Defendant tries to attribute to it. The statement does not specifically address Plaintiff's occupation.

Defendant's argument that its denial of Plaintiff's claim was reasonable.

Particularly significant is Defendant's failure, contrary to the repeated advice of its own internal medical consultants, to obtain an IME. The AUL administrative record reveals that, on March 21, 2001, AUL adjuster Linda Cross referred Plaintiff's November 2000 application for benefits to a "RN medical consultant" for review with respect to "impairment beyond March 31, 3001."[44] A determination that additional, current medical information was necessary followed, along with a recommendation that an IME, with a current echocardiogram, stress test and EKG, if needed, be obtained.[45] Consistent with this recommendation,

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Additionally, Dr. Bethea's records indicate that Plaintiff was to receive follow-up care from Dr. Cook. *See* October 24, 2000 Discharge Summary, AUL000859. As indicated, Dr. Cook believes Plaintiff's follow-up care to require a career change. Furthermore, as stated herein, Defendant never asked Dr. Bethea to explain his notes or to provide an opinion regarding Plaintiff's condition and possible return to his litigation practice.

[44] *See* March 21, 2001 Referral Form to RN Medical Consultant, AUL000289.

[45] On March 22, 2001, Defendant's medical consultant, Nurse Leslie Walls, after reviewing Plaintiff's benefits application and medical records, and talking with Assistant Medical Director Dr. Nina Smith about Plaintiff, stated that she was "unsure if objective medical evidence supports impairment at this time." *See* March 22, 2001 RN Medical Consultant Referral Response, AUL000290-93. She further indicated that Dr. Smith "agrees that we need current medical information to make a determination."

Defendant informed Plaintiff, on or around April 27, 2001, that his medical records were inconclusive with regard to his "*current* impairment"; therefore, an IME with a board-certified cardiologist would be necessary."[46]

That Defendant had determined that an IME was necessary is further evidenced in its May and June 2001 internal records, correspondence with the outside vendor, GENEX Services, Inc., retained to set up the IME, and correspondence to Plaintiff.[47] Defendant's

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Id. Specifically, "[w]e need to know what his left ventricular function/ejection fraction is before we can determine the extent of his impairment. "*Id.* Nurse Walls stated that a post-bypass stress test and echocardiogram would provide the relevant information, and suggested that efforts be made to obtain Plaintiff's cardiac rehab medical records and records from Dr. Bethea. *Id.* On April 18, 2001, Nurse Walls again consulted with Dr. Smith, and reported that Dr. Smith "suggests an IME with a current echocardiogram, stress test and EKG, if needed," to confirm whether Plaintiff could perform his job. *See* RN Medical Consultant Referral Response, AUL000283-84. On September 7, 2001, Nurse Walls reported: "still unsure if objective medical evidence supports impairment at this time due to the fact that we have never received post-bypass echocardiogram results that reveal [patient's] ejection fraction and ventricular function."*See* September 7, 2001 RN Medical Consultant Referral Response, AUL000252-253.

[46] *See* April 27, 2001 Correspondence from Linda Cross of AUL to Plaintiff, AUL000113-14.

[47] *See* May 1, 2001 Email from Linda Cross to KCampbell, AUL000274 ("I have requested GENEX to set up an IME with a board-certified cardiologist"); May 1, 2001 Notes of Linda R. Cross

records reflect that it specified that the IME was to be conducted by a board certified cardiologist and include a current echocardiogram, stress test, and EKG.[48] A cardiac functional capacity assessment form also was to be completed.[49] Indeed, Defendant went so far as to inform GENEX that it "would like the IME consultant to be experienced with considering occupational stress," explaining that "[w]e are looking for his physical functional level along with his ability to handle the stress of his regular occupation."[50] On or around July 11, 2001, however, while GENEX was waiting for a response from the third physician it had

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of AUL, AUL000275 ("need IME with board certified cardiologist"); May 15, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL000104 ("[T]he information from Dr. Cook's office was inconclusive regarding your current impairment. Therefore, we believe it is not unreasonable to request current information via the Independent Medical Examination."); May 30, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL000271 ("an Independent Medical Examination has been requested in order to determine the extent of your current restrictions and limitations"); June 29, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL000103 (same); *see also* May 7, 2001 Correspondence from GENEX to Linda Cross of AUL, AUL000266 (confirming receipt of referral for coordination of IME); July 6, 2001 Initial Report of GENEX, AUL000254 (retained to establish a second cardiology evaluation for the Insured and to secure background information toward factors of stress related to return to work and occupational limitations).

[48] May 1, 2001 Notes of Linda R. Cross of AUL, AUL000275.

[49] *Id.*

[50] *See* June 6, 2001 AUL Phone Report of Contact, AUL000262.

contacted about conducting the IME, Defendant abruptly informed GENEX that an IME would not be necessary.[51]

Defendant's reasons for deciding not to do an IME are unclear from the record, and have never been adequately explained in Defendant's submissions to the Court. In subsequent internal email, Steve Torrence of AUL states: "We decided not to do an IME. We contacted two cards and both refused to do the examination, (reasons unknown) and by that time the medical indicated he was ok from a cardiac so we didn't think it would be of value."[52] Mr. Torrence's explanation, however, is not adequately supported by the record. The Court has not found, and Defendant has not identified any documentation in the record reflecting Defendant's receipt of new medical records or a new physician opinion between July 5, 2001 and July 11, 2001. At most, the Court notes that Plaintiff submitted an "Insured's Group Disability Supplemental Statement," at Defendant's request, on

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[51] *See* July 11, 2001 Correspondence from Donald Crais of GENEX to Andrew Eagan of AUL, AUL000260. Interestingly, the record indicates that the third physician contacted by GENEX, Dr. David Elizardi, bears the same name as the physician who performed Plaintiff's prebypass angiography on October 2, 2000. *See* July 5, 2001 Correspondence from GENEX to Dr. David J. Elizardi, AUL 000258-59; Operative Report of Dr. David Elizardi, AUL000879-80. It is not clear from the record, however, whether the two physicians actually are the same person or simply have the same first and last names.

[52] *See* April 12, 2002 Email from Steve Torrence to Kimberly Campbell, AUL 000228.

or around July 10, 2001, indicating that he still was unable to practice litigation, but had begun practicing business, energy, and international law, and was doing some investing.[53]

Furthermore, rather than abandoning its quest for additional post-bypass test results for Plaintiff, which were to be conducted as part of the IME, Defendant thereafter continued its pursuit of a post-bypass echocardiogram and a supplemental physician statement from Dr. Cook.[54] In fact, Andrew Eagan of AUL continued to request post-bypass echocardiogram results even after AUL medical consultant Nurse

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[53] *See* Insured's Group Disability Supplementary Statement, AUL000251.

[54] *See* July 13, 2001 AUL Group Disability File Memo by Nurse Walls, AUL00257 (evidencing efforts to obtain post-bypass echocardiogram from Dr. Cook's office, the hospital, and/or Dr. Bethea); July 16, 2001 Correspondence from Andrew Eagan of AUL to Dr. Bethea, AUL000214 (requesting medical records from October 2000 to the present); July 30, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL000099 (additional benefits conditioned on receipt of previously requested Supplemental Attending Physician Form); July 31, 2001 Second Request for Medical Records to Memorial Medical Center, AUL000215; September 7, 2001 RN Medical Consultant Referral Response, AUL000252-53 ("still unsure if objective medical evidence supports impairment at this time due to the fact that we never received post-bypass echocardiogram results that reveal [patient's] ejection fraction and ventricular function"); October 22, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL 000038 (suspending good faith payments pending receipt of post-bypass cardiogram and verification of continued regular medical treatment).

Leslie Walls had determined, on or around September 7, 2001, that neither Dr. Cook, Dr. Bethea, nor the hospital had that record, and surmised that the test had not been performed.[55]

On October 26, 2001, Plaintiff explained to Defendant that it had not received a post-bypass echocardiogram because one had not been performed.[56] This is significant because Defendant's medical consultant had advised, on or around March 22, 2001, that "[w]e need to know what [Plaintiff's] left ventricular function/ejection fraction is before we can determine the extent of his impairment," and that that information could be obtained from a post-bypass stress test *and* echocardiogram.[57] As of November 9, 2001, however, Defendant did not have the required echocardiogram; it had only up-to-date treadmill stress tests results.[58] With just that additional information, Nurse Walls' November 9, 2001 review offered only

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[55] *See* Note 54.

[56] *See* October 26, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL 00032-33. Plaintiff provided this information in response to Defendant's October 22, 2001 notice that it was suspending payments pending receipt of a post-bypass echocardiogram. *See* Note 54.

[57] *See* Note 54 (emphasis added).

[58] *See* October 31, 2000-November 8, 2001 AUL Group Disability File Memo, AUL000245 (reflecting Nurse Walls' receipt of October 8, 2001 treadmill stress test on November 8, 2001).

that "[i]t *appears* there may be a lack of objective evidence to support an impairment at this time."[59]

Despite becoming aware that medical evidence that its own medical consultant had said was necessary, and that it had actively pursued for months, simply did not exist, Defendant did not renew its request for an IME and/or echocardiogram. Instead, it issued its November 20, 2001 denial, apparently deciding to go with *management's* recommendation regarding the claim, rather than pursuing an echocardiogram and/or an independent opinion from another cardiologist.[60]

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[59] *See* November 9, 2001 RN Medical Consultant Referral Response, AUL000244 (emphasis added).

[60] *See* November 15, 2001 AUL Internal Memo, AUL000248 ("Management was consulted and the recommendation is to deny the claim."). The November 20, 2001 letter denying Plaintiff's application for disability benefits references Dr. Cook's October 8, 2001 examination report and the results of Plaintiff's treadmill stress test (exercise to 12.5 METS on Bruce Protocol and achieving 85% of target heart rate). *See* November 20, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL000016-19. Even considering that progress, however, it was Dr. Cook's professional opinion, as of November 1, 2001, that Plaintiff still should refrain from a litigation practice and that his Current GAF was Class 3, indicating that he was "able to engage in only limited stress situations and engage in only limited interpersonal relationships." *See* November 1, 2001 Attending Physician's Statement, AUL00026; *see also* December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15 (Dr. Cook's November 1, 2001 report took into consideration all diagnostic testing including the October 2001 stress test). In addition, the Court notes that Plaintiff has explained in his submissions that the *ACC/AHA 2002 Guideline*

Attempting to defend its rejection of Plaintiff's total disability status without the support of a contrary IME, Defendant remarks: "Interestingly, it is House's longtime personal physician, Dr. Cook, who has pronounced House disabled due to his heart condition, and not Dr. Bethea, the physician performing surgery on House, or Dr. Elizardi, the physician performing angiography on House."[61] Even more interesting, however, is *Defendant's* own failure to seek an opinion regarding Plaintiff's status from Dr. Bethea or Dr. Elizardi, given its disagreement with Dr. Cook's opinion, its decision to not obtain an IME, and the absence of a post-bypass echocardiogram.

Indeed, although objecting to Dr. Cook's assessment of Plaintiff's medical condition, the record does not reflect, and Defendant has not identified, a single instance where it sought to have Dr. Cook further explain his continued opinion that, although Plaintiff's post-bypass stress test results showed apparent improvement in Plaintiff's physical condition, Plaintiff remained unable to practice litigation. What

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Update for Exercise Testing (2002), published by the American Heart Association, states:

> Exercise testing in an asymptomatic patient who has undergone successful coronary bypass grafting is not predictive of subsequent events when the test is performed within the first few years after the revascularization procedure.

See Plaintiff's November 5, 2002 Memorandum at 6.

[61] *See* Defendant's October 29, 2002 Memorandum at 18.

is more, Defendant completely fails to even entertain the possibility that Plaintiff's recovery—in terms of improved stress tests and lack of symptoms—can be attributed, at least in part, to Plaintiff's decision to accept Dr. Cook's recommendation that he not return to a litigation practice.

Other arguments advanced by Defendant in support of its conduct are similarly objectionable. For instance, Defendant contends that "Dr. Cook made no differentiation [between] the effect of Mr. House's heart based on running 5 miles several times a week and occupation stress."[62] Once again, if Defendant questioned why Dr. Cook apparently had no objection to Plaintiff running 5 miles several times a week, but said that Plaintiff could not be a trial lawyer, Defendant should have asked him that, or should have sought an IME from another cardiologist. It did not.[63] Instead, it has decided to rely on its own speculation and generalizations. For instance, it argues that "it is very well known that persons with a history of cardiac bypass surgery engage in very stressful occupations. There was no evidence offered as to why Mr. House should be disabled based on that status, when others

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[62] *See* Defendant's January 14, 2003 Brief at 21.

[63] *See* September 19, 2002 Affidavit of John R. Cook, M.D., ¶ 3.7 ("At no time did AUL ever question me regarding the opinion of any other doctor, and, except for the above listed requests for information, at no time did AUL seek information from me as to the care or continued treatment of Mr. House."), submitted with Plaintiff's October 4, 2002 motion for partial summary judgment.

are able to continue to function in such occupation."[64] When measured against the expert opinion of a board certified cardiologist who is also Plaintiff's long-time treating physician, such speculation and generalizations alone simply were not reasonable bases on which to deny Plaintiff's claim.

b. "Trial Attorney" v. "An Attorney"

As stated above, Defendant also argues that Plaintiff makes an unsupported and artificial distinction between his current employment and his occupation while at the House Firm. It contends: "House's attempts to create sub-specialties of the legal profession and complain of his inability to practice within one of them should be unavailing."[65] Consistent with this argument, Defendant asserted, in its November 20, 2001 denial of Plaintiff's application for benefits, that Plaintiff's "regular occupation at the onset of [his] disability was an Attorney."[66] It additionally stated, "[t]he determination of your claim is that you are capable of performing the duties of your *regular occupation* full time. You appear to be capable of performing the sedentary occupation of an Attorney as it is normally performed in the national economy."[67] Defendant does not explain what it views to be the

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[64] *See* Defendant's January 14, 2003 Brief at 21.

[65] *See* Defendant's October 29, 2002 Memorandum at 16.

[66] *See* November 20, 2001 Correspondence from Andrew Eagan of AUL to Plaintiff, AUL000016-19.

[67] *Id.* (emphasis in original).

material and substantial duties of "the sedentary occupation of an Attorney as it is normally performed in the national economy." Indeed, the Court finds such a statement rather enigmatic.

In any event, there is no basis in this case for concluding that Plaintiff's "regular occupation," for purposes of the House policy, should be defined as anything other than a "trial attorney." The House policy does not define the phrase "regular occupation." Further, to the extent that the phrase reasonably can be construed to mean a specific type of law or specialty within the practice of law, as well as the practice of law generally, the policy provision is ambiguous. Defendant is well aware that policy ambiguities are construed in favor of the insured. Finally, until management's decision to deny Plaintiff's claim was communicated to him on November 20, 2001, Defendant never suggested to Plaintiff that it viewed his regular occupation as anything other than a trial attorney. In fact, on March 2, 2001, Defendant sent a letter to Plaintiff specifically identifying his regular occupation to be that of a trial attorney.[68]

Defendant's internal documents likewise are replete with references to Plaintiff's regular occupation as a trial attorney.[69] In fact, Defendant's records show

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[68] *See* March 2, 2001 Correspondence from Linda Cross of AUL to Plaintiff, AUL 000159-63 (referring to Plaintiffs "regular occupation" and "own occupation" as "trial attorney").

[69] *See, e.g.*, March 21, 2001 Referral Form to RN Medical Consultant, AUL000289 (identifying occupation as "trial attorney"); March 22, 2001 RN Medical Consultant Referral

that it was recommended to Defendant's claims adjuster that he send a questionnaire to Plaintiff to determine "if [Plaintiff] was in fact functioning as a trial attorney before we decide the next steps."[70] Similarly, Defendant's representative reviewing the denial of Plaintiff's appeal specifically inquired whether it had been confirmed that Plaintiff was, in fact, a trial attorney.[71] She explained that, contrary to the assertion made in Defendant's November 20, 2001 denial letter, "[a] trial attorney is not a sedentary occupation and cannot standardly be done in a 40 [hour] work week."[72] The same representative further emphasized that "[i]t's quite one thing to have 'billable' hours in the support of a trial but quite another to be the lead trial attorney in court."[73]

Defendant's failure for months to assert that Plaintiff's regular occupation was as "an attorney" generally, rather than a "trial attorney," is telling. Neither Plaintiff nor Dr. Cook have ever contended,

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Response, AUL000290-93 (same); April 27, 2001 AUL Claim Summary by Linda Cross, AUL000278 (stating that Plaintiff worked as a trial attorney); April 12, 2002 Email from Steve Torrence to Kimberly Campbell, AUL000228 (confirming that there was documentation in the file from Plaintiff and the House Firm that Plaintiff was a trial attorney).

[70] *See* May 16, 2001 Facsimile to Andrew Eagan, AUL000263-65.

[71] *See* April 16, 2002 Email from Kimberly Campbell to Steve Torrence, AUL00231.

[72] *Id.*

[73] *Id.*

not even in Plaintiff's November 20, 2000 application for benefits, that Plaintiff is entirely disabled from practicing any and all types of law.[74] Indeed, Plaintiff informed Defendant from the very beginning of his intention and efforts to establish a different type of legal practice.[75] If Defendant had viewed Plaintiff's regular occupation to be simply an attorney generally rather than a trial attorney, there would have been no need to expend resources in confirming Plaintiff's prior and current job descriptions in connection with a claim for Total Disability benefits.[76] To the contrary, Defendant would have had a strong argument for

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[74] *See* November 30, 2000 Group Disability Application, AUL000179-83; July 10, 2001 Insured's Group Disability Supplementary Statement, AUL000251.

[75] *See* November 30, 2000 Correspondence from Plaintiff to Defendant and Group Disability Application, AUL000172-74, 179-84 (indicating intent to continue legal practice but in area other than trial law); February 13, 2001 File Phone Memo by Linda Cross of AUL, AUL000330 (Plaintiff stated that he was looking into University teaching position and planned to do "something else"); February 22, 2001 File Phone Memo by Linda Cross of AUL, AUL000328 (Plaintiff informed Defendant that he was considering a teaching position as well as positions at other law firms that would not involve litigation and that would be less stressful).

[76] *See, e.g.*, December 20, 2000 Correspondence from Susan Fields of AUL to Randy Fath, AUL000169 (requesting for description of Plaintiff's legal practice prior to and after November 20, 2000); January 2, 2001 Note of AUL Examiner Susan Fields, AUL000334 ("I asked about the change in the definition from [Plaintiff's] previous type of law he was practicing, and what he is currently practicing.").

denying Plaintiff's request for Total Disability benefits as soon as it became aware that Plaintiff could practice a different type of law.

The evidence likewise leaves no doubt that Plaintiff adequately informed Defendant that he was a trial attorney prior to becoming disabled in October 2000, but not thereafter. In the application form that he provided to Defendant on November 20, 2000, Plaintiff identified his regular occupation (prior to his disability) as "attorney—trial practice including pretrial discovery, depos, motions and trials in federal and state court, arbitration."[77] Plaintiff also stated in his application materials that "[o]ver the 25 years that [he had] practiced law, [his] primary concentration ha[d] been trial work," and that "over 95% of [his] billable hours [were] related to trial work."[78] In a statement accompanying his November 30, 2000 application for benefits, Plaintiff additionally explained that:

> No longer being able to have a trial practice means that I will not be able to participate in pre-trial practice (such as discovery, depositions, motions and other matters before the Court) as well as the trial of cases before Federal and State Courts of Louisiana, Texas and other jurisdictions in which I have

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[77] *See* November 30, 2000 Group Disability Application, AUL000179-83.

[78] *See* Attachment to November 30, 2000 Group Disability Claim Application, AUL000184.

> practiced, as well as arbitration proceedings, locally, nationally, and internationally where I have practiced over the last 25 years.[79]

Steve Torrence of AUL similarly represented that Plaintiff had informed Defendant:

> In the one year period prior to [his] quadruple bypass surgery, [he] billed 2170 hours, tried three lengthy complicated cases, argued three appeals in four different courts of appeal, including the Louisiana Supreme Court and took or participated in depositions, argued numerous trial court motions, and engaged in court supervised settlement conferences resulting in the settlement of more than 20 active cases].[80]

According to Plaintiff, he spent an average of 185 billable hours per month performing trial and appellate work in the year preceding his open heart surgery.[81] Martindale-Hubbell's Online Lawyer

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[79] *See* November 30, 2000 Group Disability Claim Application, AUL000184.

[80] *See* April 12, 2002 Email from Steve Torrence of AUL to Kimberly Campbell, AUL000224; March 16, 2001 Correspondence from Plaintiff to Linda Cross of AUL, AUL000154-156.

[81] *See* March 16, 2001 Correspondence from Plaintiff to Linda Cross of AUL, AUL000154-156. Plaintiff provided Defendant with his time records for October 1999 through September 2000. *See* July 10, 2001 Insured's Group Disability Supplementary

Locator additionally showed Plaintiff's pre-bypass occupation to have been litigation.[82]

The description of Plaintiff's work provided by Randy Fath, Manager of the House Firm, confirms that Plaintiff's work prior to November 16, 2000, was "complex litigation" and thereafter involved transactional matters and counseling clients and other attorneys in the preparation of pleadings.[83] Other submissions by Plaintiff to Defendant likewise confirmed that after submitting his application for benefits he did only non-litigation work, and that the material and substantial duties of his work therefore changed.[84] With respect to Plaintiff's current

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Statement, AUL000251 (reflecting that time records had been furnished).

[82] *See* April 26, 2001 Martindale-Hubbell Lawyer Locator, AUL 000118-119.

[83] *See* January 1, 2001 Correspondence from Randy Fath of the House Firm to Ms. Susan Fields, AUL000157 (explaining change in nature of Plaintiff's legal practice since November 16, 2000).

[84] In February 2001, Plaintiff informed Defendant that he was considering a teaching position as well as positions at other law firms that would not involve litigation and that would be less stressful. *See* February 22, 2001 File Phone Memo by Linda Cross of AUL, AUL000328. Plaintiff later reported that he had commenced a new type of legal practice. *See* July 10, 2001 Insured's Group Disability Supplementary Statement, AUL000251 ("Since March 1, 2001, [I] have engaged in the practice of business, energy, and international law. . . . [I] cannot practice trial law. . . ."); December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15 ("I have not

employment as Executive Counsel of the Louisiana Department of Economic Development, he explained:

> I advise the Secretary of the Department on all matters relating to economic development goals and policies, including legislative and administrative incentives for retaining, expanding and obtaining businesses and good jobs for the people of Louisiana. The position does not and will not include litigation duties. Though I have returned to work, I have not, because of medical restrictions, resumed my trial practice.[85]

c. Work Stress-Litigation v. Non-Litigation

As previously explained, Defendant further defends its actions based on the argument that, even if Plaintiff's former occupation was as a "trial attorney," rather than "an attorney" generally, Plaintiff has not demonstrated that the "material and substantial duties" of his present occupation, Executive Counsel to the Louisiana Department of Economic Development, are any less stressful that those of a trial attorney. The Court finds this position to be unreasonable.

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returned to the practice of trial law. I have . . . obtained other gainful employment. As you know, I have practiced business, international, and energy law since March, 2001 and became Executive Counsel of the Louisiana Department of Economic Development on October 15, 2001.").

[85] See December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15.

From the time that Plaintiff sought benefits on November 30, 2000, he and Dr. Cook, a board-certified cardiologist and Plaintiff's longtime physician, repeatedly informed Defendant of Dr. Cook's belief that Plaintiff was no longer capable of practicing trial law, but could tolerate a different type of law practice.[86] Likely significant to this conclusion was the fact that Plaintiff worked, and had worked for twenty-five years, as a trial attorney when he suffered a heart attack in 1999. Then, just one year later, during which time Plaintiff billed more than 2000 hours in trial, pretrial, and appellate work, he required emergency quadruple bypass surgery. Also important is Dr. Cook's determination that Plaintiff was "able to engage in only limited stress situations and engage in only limited interpersonal relations."[87] Contrary to this limitation, the form submitted by Plaintiff to Defendant, on March 25, 2001, identifies the "unusual mental and/or physical requirements" of his job at a trial attorney as "intense and stressful involvement of trial work with clients, courts and opposition."[88] Indeed, noting his absence of typical risk factors for heart disease, Plaintiff attributes the stress

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[86] *See* Notes 40 and 41.

[87] *See* November 30, 2000 Group Disability Claim Application, AUL000181.

[88] *See* March 25, 2001 Training Education and Experience form, AUL000148-49.

of having a trial practice is an important factor in the causation of his heart disease.[89]

Significantly, as Plaintiff's December 17, 2001 letter emphasized to Defendant, his present job as Executive Counsel to the Louisiana Department of Economic Development does not, and will not require, him to partake in adversary litigation activities. Accordingly, he has not and will not be exposed to the stress presented by interaction with and opposition from clients, the courts, and opposing counsel in the

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[89] Dr. Cook concurs. *See* Note 40. In the attachment to his application for disability benefits, Plaintiff explained:

> Over the 25 years that I have practiced law, my primary area of concentration has been trial work. During that time, over 95% of my billable hours have been related to trial work. . . . Given the various factors that cause heart disease[,] as well as the fact that *none* of the primary indicators for heart disease (such as smoking, heredity, overweight or high cholesterol) have been present in my case at the time of my disability, it [is] highly likely that the stress of having a trial practice is an important factor in the causation of my heart disease.

See November 30, 2000 Group Disability Claim Application, AUL000184; *see also* December 17, 2001 Correspondence from Plaintiff to Andrew Eagan of AUL, AUL000012-15 ("my discontinuance of a trial practice has undoubtedly been the significant factor in my recovery since I have a long history of exercise, no family history of heart disease or personal history of smoking, or any of the other risk factors for heart disease, except for the high stress of my trial practice").

course of litigation, including discovery, motion practice, trial, and appeal.[90]

Statements by Defendant's representatives likely demonstrate, at least in part, why Dr. Cook believed a litigation practice to be more harmful to Plaintiff than other legal work. As previously indicated, AUL representative Kimberly Campbell explained that being a "trial attorney is not a sedentary occupation and cannot standardly be done in a 40 [hour] work week."[91] Similarly, when Plaintiff informed Adjuster Linda Cross, on February 22, 2001, that he was considering a teaching position, as well as positions at other firms that would not involve litigation and would be less stressful, she commented that his time records showed that he worked 12-14 hour days each time that he went to trial.[92] Plaintiff responded that he was "doing that back when he had his heart attack in 10/99."[93]

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[90] Other employment undertaken by Plaintiff between the time he left the House Firm and when he accepted the Executive Counsel position likewise did not involve litigation. *See* Notes 11 and 84.

[91] *See* April 16, 2002 Email from Kimberly Campbell to Steve Torrence, AUL00231.

[92] *See* February 22, 2001 File Phone Memo by Linda Cross of AUL, AUL000328. Ms. Cross's memo does not indicate that she, at that time, questioned whether a teaching or nonlitigation position would be less stressful than a litigation practice.

[93] *Id.*

Also significant, once again, is Defendant's failure, when presented with Dr. Cook's professional opinion that Plaintiff still could work as lawyer, but not a litigator, to ask him to elaborate on this distinction, or to require Plaintiff to obtain that information. Nor did Defendant seek an opinion on the matter from an independent cardiologist, or other medical or vocational expert. To the contrary, Defendant simply chose to deny Plaintiff's claim and then to resort to generalizations and speculation when called to defend that conduct.[94] The Court finds that, in acting in this manner, Defendant was arbitrary and capricious in its handling of Plaintiff's claim.[95]

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[94] *See* Defendant's October 29, 2002 Memorandum at 18-19 (emphasis added) (Plaintiff's position as Executive Counsel to the Louisiana Department of Economic Development "is *presumably* rife with much responsibility and demands . . . and *presumably* all the more stressful when performed at a level that merits recognition as 'State Executive of the Year' by the New Orleans Chamber of Commerce); Defendant's January 14, 2003 Brief at 21 (emphasis added) ("Mr. House reported that he was working in an *apparently* responsible position; there was no basis for AUL to conclude Mr. House was less 'stressed' in that position than in trial work") and ("it is very well known that persons with a history of cardiac bypass surgery engage in very stressful occupations. There was no evidence offered as to why Mr. House should be disabled based on that status, when others are able to continue to function in such occupation.").

[95] The Court finds *Brown v. Washington National Insurance Company*, 942 F. Supp. 1078 (E.D. La. 1996), and *Cooper v. Paul Revere Life Insurance Company*, 1997 WL 375884 (E.D. La.), distinguishable from the instant case for the reasons stated in the December 3, 2002 Order and Reasons at 23-24.

2. Partial Disability Benefits

The Court likewise finds that Defendant has acted arbitrarily and capriciously in failing to pay Partial Disability benefits to Plaintiff. Importantly, Defendant informed Plaintiff on March 2, 2001, that he "[was] considered Partially Disabled from November 16, 2000 until [he] ceased work activity in 2001."[96] After denying Plaintiff's request for Total Disability Benefits in November 2001, however, Defendant did not commence payment of Partial Disability benefits. In fact, it never even bothered to respond to Plaintiff's counsel's query as to why he should not at least receive Partial Disability Benefits.[97]

In any event, for much the same reasons that Defendant was arbitrary and capricious when it denied Plaintiff's entitlement to Total Disability benefits, Defendant's failure to pay Partial Disability benefits to Plaintiff after he returned to work was similarly egregious. As explained above, Defendant acted unreasonably in concluding that Plaintiff could perform the material and substantial duties of his regular occupation as a trial attorney. There likewise could be no question that Plaintiff was performing "at least one of the material and substantial duties of . . .

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[96] *See* March 2, 2001 Correspondence from Linda Cross of AUL to Plaintiff, AUL000159-163.

[97] *See* April 2, 2000 Correspondence from Felix Weill to Kimberly Shaw of AUL, AUL000004-7; May 7, 2002 Correspondence from Steve Torrence to Felix Weill, AUL 000001 (communicating disagreement with Plaintiff's disabled status and failing to address query regarding Partial Disability benefits)

another occupation on a part-time or full-time basis" when he began practicing business, energy, and international law, or when he assumed his Executive Counsel position.[98] Finally, at least as of January 2001, it was undisputed that Plaintiff earned less than 80% of his Indexed Pre-Disability Earnings because of his heart condition.[99]

IV. Calculation of Benefits, Penalty, Attorney's Fees, Judicial Interest, and Costs

The Court has determined that Plaintiff presently is entitled to receive Total Disability benefits or Partial Disability benefits, subject to applicable offsets for income from other employment. Because Plaintiff's election will affect other relief sought by Plaintiff, the Court will not determine the dollar amount of benefits, penalty, attorney's fees, and/or judicial interest and costs at this time. Instead, **IT IS ORDERED** that Plaintiff shall inform the Court on or before April 30, 2004, whether it presently seeks to recover Total Disability or Partial Disability benefits. Then, on or before May 20, 2004, the parties are to file submissions with the Court regarding the appropriate dollar amount of benefits, penalty, attorney's fees, interest and costs. The parties are urged to enter into stipulations, where possible, regarding any or all of these amounts. **IT IS FURTHER ORDERED** that the parties schedule a settlement conference with Magistrate Judge Knowles to be held on or before May

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[98] *See* Notes 11 and 84.

[99] *See* Note 12.

28, 2004, if Magistrate Knowles has time available on or before that date for a conference with the parties.

CONCLUSION

By seeking summary judgment regarding his entitlement to Total Disability benefits under the House Policy, Plaintiff did not abandon or waive his right to alternatively seek payment of Partial Disability benefits. Defendant is correct, however, that Plaintiff cannot actually recover Total Disability Benefits *and* Partial Disability Benefits. Thus, Plaintiff must choose which benefits he would like to recover.

The Court does not find that the House Policy is part of the same "plan," for purposes of ERISA, as the disability insurance coverage provided by the House Firm to its employees. Accordingly, Plaintiff's claim for a penalty and attorney's fee award under La. R.S. 22:657 is not preempted.

The Court concludes that Defendant abandoned its efforts to reasonably investigate Plaintiff's claims for disability benefits. Rather than obtaining the additional objective medical evidence and an independent medical examination that it originally asserted was necessary to a proper evaluation of claim, Defendant's decision instead rested on assumptions it made about Plaintiff's undertaking of a non-litigation legal practice, his ability to tolerate strenuous exercise, and his improving results on treadmill stress tests. In addition, despite initially informing Plaintiff that he was Partially Disabled, Defendant did not pay Plaintiff any disability benefits after September 30,

2001, and simply ignored Plaintiff's subsequent query regarding his entitlement to Partial Disability benefits. Under these circumstances, the Court finds that Defendant's denial of Plaintiff's claim for benefits was not based on just and reasonable grounds. Accordingly, the Court shall impose a penalty and attorney's fee award against Defendant under La. R.S. 22:657 upon submission of the additional information sought herein.

New Orleans, Louisiana, this 19th day of April 2004.

/s/
KURT D. ENGELHARDT
UNITED STATES DISTRICT JUDGE

cc: Magistrate Judge Knowles

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

No. 02-1342

[Filed December 3, 2002]

WALTER RICHARD, HOUSE, JR.	)
	)
VERSUS	)
	)
AMERICAN UNITED LIFE INSURANCE COMPANY	)
	)

ORDER AND REASONS

The matter is before the Court on cross-motions for summary judgment, which have been the subject of extensive briefing. The motions were heard on Wednesday, November 13, 2002. The parties filed post-hearing memoranda. Having considered the summary judgment record, the applicable law, memoranda filed by the parties, and the argument of counsel, the Court GRANTS plaintiff's Motion for Partial Summary Judgment and DENIES defendant's Motion for Summary Judgment.

I. Plaintiff's Motion for Partial Summary Judgment

A. Procedural and Factual Background

This is an action on a policy of disability insurance bearing Certificate Number 46178808840 (the "Policy") effective May 1, 2000 to the plaintiff, Walter Richard House, Jr. ("House"), as Insured, by the defendant American United Life Insurance Company ("AUL").[1] The Policy also bears Participating Unit Number 00603172-0000-000.[2] House, formerly a partner in the law firm of House, Kingsmill & Riess, L.L.C., filed this action against AUL claiming "totally disability" as of October 2, 2000, when he could no longer perform the material and substantial duties of his regular occupation as a trial attorney.[3] Alternatively, plaintiff claims he became "partially disabled," and eligible for the maximum monthly benefits under the Policy (*i.e.*, $10,000 per month).[4] House further claims penalties and attorney's fees are due and owing based upon the defendant's arbitrary and capricious termination of benefits, unlawful delays in payment, and

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[1] *See* Plaintiff's Complaint filed May 6, 2002 at para. 5, filed under 28 U.S.C. § 1332 (diversity) [Rec. Doc. No. 1].

[2] *Id.*

[3] Complaint at para.6.

[4] *Id.*

misrepresentation of the terms and conditions of its Policy.[5]

AUL's defense to the plaintiff's claims for breach, *inter alia,* are based upon the assumption that the Policy is an employee welfare benefit plan. AUL answered stating that:

> [T]he policy referred to in the complaint is an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 ('ERISA') 29 U.S.C. § 1002(1). Plaintiff's claims therefore relate to an ERISA plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. § 1144(a) and relief sought is only available through Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B)."[6]

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[5] *Id.* at para. 9

[6] AUL's Answer at para. XI [Rec. Doc. No. 3].

The uncontroverted facts[7] set forth in the Plaintiff's Statement of Undisputed Facts reiterated below show the following time line of events:

- House practiced as a trial attorney, spending over 95% of his time on litigation and litigation related matters, from 1975 through September 2000.[8]

- John R. Cook M. D. ("Cook"), a board certified internist and cardiologist, has been House's primary care physician since the early 1980's.

- House suffered a heart attack on October 9, 1999.

- After a short convalescence, Dr. Cook cleared House to return to his trial practice,

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[7] AUL came forward with no countervailing evidence with respect to any of the facts set forth in Plaintiff's Statement of Undisputed Facts as required. Instead, AUL denied statements numbered 1-4, 6 and 7 for lack of sufficient information to justify a belief therein, and denied statements numbered 5 and 8 as written, as though the Plaintiff's Statement was merely a complaint. AUL does not suggest that House's Motion for Partial Summary Judgment is premature. To the contrary, AUL filed a cross-motion for summary judgment seeking dismissal of plaintiff's claims in their entirety.

[8] *See* AUL's Statement of Undisputed Facts No. 27 (noting that on his application for disability benefits, House listed his occupation as "attorney-trial practice including pre-trial discovery, depos, motions and trials in federal and state court. . . .")

and, from the date of his return through September 2000, House spent over 2,100 billable hours working on litigation matters for clients.[9]

- American United Life Insurance Company ("AUL") issued a disability policy AUL Certificate No. 4617880840 to House, effective on May 1, 2000.[10]

- Based on abnormalities shown by a treadmill stress test on October 2, 2000, and the results of angiography, House underwent quadruple coronary artery bypass surgery on October 4, 2000.[11]

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[9] AUL's Statement of Undisputed Facts No. 5 admitted by House, to wit: "5. On October 11, 1999, House underwent a "[s]uccessful percutaneous transluminal coronary angioplasty and stenting of the distal as well as ostial portion of the right coronary artery" (AUL 900).

[10] AUL Policy attached to the Affidavit of Julian Good as Good #2. In its answer, AUL admitted the existence of the AUL disability insurance policy bearing Certificate Number 46178808840 effective May 1, 2000 issued to House, however, it avers that the policy referred to in plaintiff's complaint is an ERISA plan. *See* AUL's Answer at para. XI. There is no evidence in the summary judgment record or AUL's file which suggests that the policy referred to in plaintiff's complaint effective May 1, 2000 and attached to the Affidavit of Julian Good as Good #2 was not issued to House.

[11] *See* AUL's Statement of Undisputed Facts No. 12 (admitting that Dr. Morrison Bethea performed a 4 vessel cardiac bypass grafting the left anterior descending, the second diagonal branch

- It is the uncontroverted opinion of Dr. Cook that, since his bypass surgery, House has been "totally and permanently disabled from practicing law as a trial attorney," and that returning to the stress of trial work, against Dr. Cook's instructions, "could cause severe medical repercussions, including death."[12]

- Despite the fact that Dr. Cook has repeatedly relayed his opinions to AUL, it has failed and refused to pay any disability benefits to House under its policy for any period after September 30, 2001.[13]

"Total Disability" means "that because of injury or Sickness the Person cannot perform the material and

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of the left anterior descending, the circumflex, and the right coronary artery (AUL000859)).

[12] Cook Affidavit, at paras. 3.6 and 3.9; *see also* AUL's Statement of Undisputed Facts Nos. 25, 30, 33, 34 (referring to AUL 172, 790, 793, *inter alia*); AUL's File Memo at AUL 000288 (noting numerous phone calls, including one with Dr. Cook dated 4/5/01 advising that House was having (1) "residual angina at work," (2) "cannot perform litigation," (3) "has significant coronary disease" and (4) "uses nitroglycerin prn for angina").

[13] House Affidavit, at para. 20 and Dr. Cook Affidavit, at para. 3.7; *see also* AUL's Statement of Undisputed Facts No. 36, 44, 45 (referencing the denial of benefits and concluding that there was a lack of objective evidence that would prevent House from performing the material and substantial duties of his regular occupation full time).

substantial duties of his regular occupation."[14] House's regular occupation at the time of the onset of disability was "attorney-trial practice including pretrial discovery depos, motions, and trials in federal and state court. . . ."[15] The terms "material and substantial duties" and "regular occupation" are not defined in the Policy.

AUL issued a separate policy for employees of the House firm in May of 2000 with less generous monetary benefits and a less generous definition of "Total Disability" as well. After benefits have been paid for 36 months, the employee can only be "totally disabled" if he or she "cannot perform the material and substantial duties of *any* gainful occupation for which the person is reasonably fitted by training, education or experience."[16]

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[14] *See* AUL's Statement of Undisputed Facts, at item 32, stating in pertinent part that "total disability is defined as follows: 'TOTAL DISABILITY and TOTALLY DISABLED mean that because of injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation.'"

[15] *See* AUL's Statement of Undisputed Facts No. 27 (noting that on his application for benefits House listed his regular occupation as "attorney-trial practice including pre-trial discovery, depos, motions and trials in federal and state court. . . ."); *see also* Correspondence of Randy Fath dated January 2, 2001 (setting forth Houses "job description" for the period prior to September 30, 2000 in detail and noting that he has since surrendered all litigation matters to other attorneys)[AUL000157].

[16] *See* Benefits Desired for LTD Coverage for Class 3 (*i.e.*, all full-time eligible employees) (noting "3 year own occ[upation]" coverage) [AUL 000379].

During his 25 years of trial practice, over 95% of House's billable hours related to litigation. "House's job description for the period prior to and including September 30, 2000 was the representation of clients in complex litigation of construction, business torts, financing, labor insurance, securities, environmental, constitutional, oil and gas, products liability, and personal injury cases in jury and non-jury trials before State, Federal and Bankruptcy courts and in domestic and international arbitrations."[17]

Time records reflecting House's actual work for the one-year period preceding September 30, 2000 were submitted to AUL. The records corroborated the House, Kingsmill firm's representations, indicating as follows: (1) trial in the Twenty-Fourth Judicial District Court for the Parish of Jefferson in the months of May, June and July 2000; (2) trial in the Twenty-First Judicial District Court for the Parish of St. Tammany in August 2000; (3) trial in the United States District Court for the Eastern District of Louisiana in January 2000; and (4) argument before the Louisiana Supreme Court on September 14, 2000, within weeks of the

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[17] *See* Correspondence of the House firm's Business Manager responding to AUL's inquiry (also noting that such trial practice included pre-trial practice such as discovery, depositions, motions, and other matters before courts and appellate practice, including oral argument before State and Federal Appellate Courts) [AUL 000157]; Martindale-Hubbell's Online Lawyer Locator showing that House occupation as a litigator [AUL 000118-119]; Intra-Office E-mail of AUL's Steve Torrence dated April 12 2002 (noting documentation in the file from both House and the House firm his regular occupation as "trial attorney")[AUL 000224].

quadruple bypass surgery.[18] In his response to AUL's request for the "unusual mental and/or physical requirements" of his work, House described his regular occupation as "intense and stressful involvement of trial work with clients, courts and opposition."[19]

After his four-vessel coronary bypass surgery, House returned to work on November 16, 2000 to surrender all litigation matters and reassign his caseload to other attorneys and counseled clients regarding transactional matters.[20] House then left the

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[18] *See* Correspondence of Randy Fath dated April 4, 2001 (responding to AUL fax dated April 3, 2001 and explaining that non-billable, used merely to fill in the gaps in billable hours, are entered with the description "administrative," because the time does not relate to actual work) [AUL 000141]; *see also* AUL Fax dated April 3, 2001 (acknowledging its receipt of the *Detailed Fee Transaction List* provided by the House Firm's CPA/Manager Randy Fath to AUL's Senior Claims Specialist Linda R. Cross) [AUL 000141].

[19] AUL 000148-149; House Affidavit, at paras. 3-4.

[20] See AUL's Claim Summary dated February 23, 2001 (noting that the documentation provided by the House, Kingsmill firm corroborated claimant's representation that he returned to work on November 16, 2000 to reassign his caseload) [AUL 000313]. The Claims Summary provides:

> The claimant returned to work on November 16, 2000. He states this was to re-assign his caseload. The billable/non-billable hour entries on the *Detail Fee Transaction File Lists* for the most part appear to indicate this as well.
>
> For the year prior to his disability in October 2000, the claimant's average monthly billable and non-billable

litigation firm he founded, and in October 2001 accepted a salaried position in the public sector as Executive Counsel to the Louisiana Department of Economic Development ($100,000 per year), a substantial decrease from his prior salary as a litigator (*i.e.*, average earnings of $350,000 per year during the 1990's).

Although AUL's Assistant Medical Director suggested an independent medical examination (IME) on April 18, 2001, and had previously noted the need to know the left ventricular function fraction before making a determination on House's disability claim, AUL never obtained an (IME) by any physician.[21] Despite the fact that AUL's consultant reviewing House's medicals recognized that the opinion of the attending cardiologist prevails,[22] AUL terminated benefits in September of 2001 without ever obtaining a second opinion.

> hours were 225.46, including holidays, vacation hours and 80 hours of sick time in October of 1999, per the *Detail Fee Transaction File Lists* submitted by [the House, Kingsmill firm]. Per the entries, on dates for which the narrative notes "trial" claimant often worked 12-14 hr days.

Id.

[21] There is no countervailing medical opinion in the summary judgment record. AUL affirmatively decided not to get an IME. [AUL000224].

[22] *See* Initial Report dated July 6, 2001, Analysis (noting "that the neuropsychological testing information is usually negated by the opinion of the attending cardiologist") [AUL 000255].

B. Contentions of the Parties

House contends that he is "totally disabled" within the meaning of the policy, because he cannot perform the material and substantial duties of his regular occupation as a trial attorney. Moreover, House submits that his treating cardiologist's opinion is uncontroverted by any competent evidence,[23] and that regardless of the standard employed by the Court, the summary judgment record uniformly and overwhelming supports but one conclusion – *i.e.*, that he is "totally disabled."

Although unnecessary to the determination of his motion for partial summary judgment, plaintiff further argues that ERISA is clearly inapplicable to a policy which covers only partners. House urges the Court to find that AUL disingenuously raises the specter of ERISA, hoping to avoid the imposition of penalties and attorney's fees for the arbitrary and capricious termination and denial of disability benefits. Plaintiff highlights AUL's unsupported argument that it has discretionary authority to determine eligibility and to construe plan or policy terms. Finally, House contends that the Fifth Circuit's recent decision in *Lain v. UNUM Life Insurance Company of America*, 279 F.3d 377, 347 (5th Cir. 2002) supports his position. The thrust of House's position is that here, as in *Lain*, the insurance company's file contains no "concrete evidence" that after quadruple bypass surgery, House

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[23] *See* Plaintiff's Supplemental Memorandum at p. 2 (arguing that AUL's conclusion terminating benefits amounts to nothing more than lay speculation).

was capable of performing the material and substantial duties of his regular occupation (*i.e.*, trial attorney).[24]

For its part, AUL contends that evidence of the plaintiff's disability status consists *solely* of the written recommendation of his longtime personal physician, Dr. John R. Cook, that he can no longer continue as a trial attorney given the stress incumbent with that profession. AUL argues that there is not a single note in any prior medical records that House's work was unusually stressful for him or that he ever suffered any impairment due to his occupation. The defendant further chides that "such is not for this Court to decide, because ERISA governs this case, and restricts the Court to reviewing the administrative record and giving deference to AUL's determination under the deferential arbitrary and capricious standard."[25]

More specifically, AUL contends that House makes an artificial distinction between his current occupation as Executive Counsel to the Louisiana Department of Economic Development and his former occupation as partner/trial attorney with the House, Kingsmill firm. AUL's position is that the policy simply insures against the becoming disabled from the practice of law generally, suggesting that any reference to the

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[24] Plaintiff's Original Memorandum in Support of Summary Judgment, at p. 20.

[25] AUL's Memorandum in Support of Cross-Motion for Summary Judgment, at p. 2.

substantial and material duties of his pre-disability regular occupation is unnecessary.[26] Absent evidentiary support for its assertion, AUL argues in conclusory fashion that plaintiff's present occupation in the public sector is equally if not more stressful than that of a trial attorney.[27] Claiming a lack of concrete evidence and without a countervailing medical opinion, AUL asserts that the plaintiff's treating cardiologist simply diagnosed a future risk of disability.[28]

C. Summary Judgment Standard

A motion for summary judgment will be granted only if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is

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[26] *Id.* at pp.15-16.

[27] AUL urges the Court to adopt its position that the plaintiff's current public sector job is merely an extension of his former occupation, "*presumably* rife with much responsibility, many demands . . . and *presumably* all the more stressful when performed at a level that merits recognition as 'State Executive of the Year' by the New Orleans Chamber of Commerce." *Id.* at 19 (emphasis added).

[28] AUL contends that "that stress tests demonstrate that House is presently more capable than he was in the past to work as a trial attorney and that House has not demonstrated he is presently disabled only that he may be in jeopardy of becoming disabled in the future due to a stressful occupation – an insufficient showing to qualify as disabled under an ERISA policy." *Id.* at pp. 20-21.

entitled to judgment as a matter of law.[29] Any factual controversies must be resolved in favor of the non-moving party.[30] The role of summary judgment is to pierce the pleadings and to assess the proof to determine whether there is a genuine need for trial. When the parties present cross motions for summary judgment essentially they agree there are no genuine issues as to any material fact, and that the matter is ripe for resolution of their motions.

D. Standard of Review

Assuming without deciding that ERISA applies to this case, the Court sets forth the standard applicable to such claims. An administrator's denial of benefits under an ERISA plan is "reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989) (citation omitted). Because the language of the Policy does not give AUL such discretion, the Court applies the *de novo* standard of review. However, AUL's factual determinations during the course of House's benefit proceeding are reviewed for abuse of discretion. *Lain v. UNUM Life Insurance Company of America,* 279 F.3d 337, 342 (5th Cir. 2002). When applying the abuse of discretion

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[29] *See Celotex v. Catrett,* 477 U.S. 317, 106 S. Ct. 2548, 2552 (1986); *Aboul-Fetouh v. Employee Benefits Committee,* 245 F.3d 465, 471 (5th Cir. 2001); Fed. R. Civ. P. 56.

[30] *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir.1994)(*per curiam*).

standard, the Court analyzes whether the plan administrator acted arbitrarily and capriciously. A decision is arbitrary when made "without a rational connection between known facts and the decision or between the facts found and the evidence." *Lain,* 279 F.3d at 342 (*citing Bellaire General Hospital v. Blue Cross Blue Shield of Mich.,* 97 F.3d 822, 828 (5th Cir. 1999)). An administrator's decision to deny benefits must be "based on evidence, even if disputable, that clearly supports the basis for denial." *Vega v. National Life Insurance Services, Inc.,* 188 F.3d 287, 299 (5th Cir. 1999)."Without some *concrete evidence* in the administrative record that supports the denial of the claim," the Court must find "the administrator abused its discretion." *Lain,* 279 F.3d at 342 (*citing Vega,* 188 F.3d at 302).

A "sliding scale" is applied to the abuse of discretion standard where it is determined that the administrator has acted under a conflict of interest. *Vega,* 188 F.3d at 296. The greater the evidence of conflict on the part of the administrator, the less deferential a court's abuse of discretional standard should be. *Id.* at 297. In the case at bar, AUL has an inherent conflict of interest because it is the insurer and has acted as the plan administrator and the claims administrator, determining eligibility for benefits and denying claims made under the Policy. However, *Vega's* "sliding scale" need not be applied in this case, given the overwhelming evidence of House's disability and the utter absence of any concrete evidence to the contrary.

The Fifth Circuit has made it clear that "the administrative record consists of the relevant

information made available to the administrator *prior to the complainant's filing of a lawsuit* and in a manner that gives the administrator a fair opportunity to consider it." *Vega,* 188 F.3d at 300. Declining to remand to the administrator to make more complete record, the *Vega* court explained that since "the claimant only has an opportunity to make his record before he files suit in federal court, it would be unfair to allow the administrator greater opportunity at making a record than the claimant enjoys." *Vega,* 188 F.3d at 302 n. 13.

E. Discussion

1. Disability

In assessing whether to grant or deny benefits, an administrator must: (1) determine the facts underlying the claim; and then (2) determine whether the facts establish a claim to be honored under the terms of the policy. *See Lain,* 279 F.3d at 243 (*citing Schadler v. Anthem Life Insurance Co.,* 147 F.3d 388, 394 (5th Cir. 1998)). AUL argues that, based on established facts, House is not disabled as defined under the Policy.

The Policy provides:

> **Disability and Disabled** mean both Total Disability and Totally Disabled and Partial Disability and Partially Disabled.
>
> * * *
>
> **Total Disability and Totally Disabled** mean that because of Injury or Sickness the Person

cannot perform the material and substantial duties of his regular occupation.

Partial Disability and Partially Disabled mean that because of Injury or Sickness the Person, while unable to perform every material and substantial duty of his regular occupation on a full-time basis, is:

1. performing at least one of the material and substantial duties of his regular occupation or another occupation on a part-time or full-time basis; and

2. is earning less than 80% of his Indexed Pre-Disability Earnings due to that same Injury or Sickness.[31]

AUL asserts that House is not disabled under the first-prong of definition of disability because he has failed to present any evidence that he is unable to perform all of his material duties as an attorney generally.[32] AUL fails to explain why House should not be considered at least partially disabled within the meaning of the Policy. The "administrative record" is devoid of competent factual and medical evidence supporting AUL's argument or determination that

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[31] Policy, Section 2 - Definitions [AUL 000395].

[32] House asserts in the alternative that he is disabled under the second-prong of the analysis. AUL does not even attempt to meet the plaintiff's alternative argument that he is and was entitled to partial disability payments during all phases of the benefit determination.

House's current occupation in the public sector is equally as stressful, if not more so, than that of a trial attorney. AUL submits that its termination of benefits is justified in light of the improved results on certain stress tests, House's ability to engage in strenuous physical exercise, and his superior performance in the position of Executive Counsel.

2. The Legally Correct Interpretation

The Fifth Circuit applies a two-prong test when reviewing an administrator's denial of benefits. First, the district court must determine the "legally correct interpretation of the policy." *Lain,* 279 F.3d at 344 (*citing Tolson v. Avondale Industries, Inc.,* 141 F.3d 604, 608 (5th Cir. 1998)). In ascertaining the legally correct interpretation, the Court considers (1) whether a uniform interpretation of the policy has been given by the administrator, (2) whether the interpretation is reasonable, and (3) whether the unanticipated costs will result from a different interpretation of the policy. *Gosselink v. AT&T, Inc.,* 272 F.3d 722, 726 (5th Cir. 2001) (*citing Wildbur v. ARCO* Chem. Co., 974 F.2d 631, 637-38 (5th Cir. 1992)).

There has been no allegation as to whether AUL gave the Policy a uniform interpretation. Nevertheless, AUL's own claims file admits that it was necessary to make the determination of whether or not House was a "trial attorney," in order to determine the propriety of a decision to terminate and/or deny benefits under the Policy. The evidence before the Court indicates AUL invested some time and effort attempting to determine whether House's pre-disability occupation

was in fact as a "trial attorney" or as an "attorney." [33]

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[33] *See* E-Mail of AUL's Kimberly Campbell dated April 11, 2002 addressed to AUL's Steve Torrence (inquiring as to whether a determination was made as to whether House was or was not a "trial attorney") [AUL 000224]. Ms. Campbell's questions directed to Mr. Torrence reiterated below are telling in regard to AUL's interpretation of the Policy term "regular occupation," to wit:

> I did receive the information you provided and have a couple of questions that we are still not clear on. Have you established whether or not Mr. House was a *trial attorney*? It's one thing to have "billable" hours in the support of a trial but quite another to be the lead trial attorney in court. If it was determined that he was not a trial attorney what information was used to make the determination? If it has not then I would not be able to determine if a denial was appropriate. Our last note to Andrew Eagan at AUL indicated that *we needed to determine if the claimant was a trial attorney* prior to taking next steps. . . We never got any further information. . . .

Id.(emphasis added) [AUL 000224-225]; *see also* E-Mail Reply of AUL's Steve Torrence dated April 12, 2002, stating that:

> We do have documentation in the file from both Mr. House (of course) and the employer that House was a *trial attorney*. House stated - 'In the one year period prior to my quadruple by pass surgery, I billed 2170 hours, tried three lengthy complicated cases, argued three appeals in four different courts of appeal, including the Louisiana Supreme Court and took or participated in depositions, argued numerous trial court motions, and engaged in court supervised settlement conferences resulting in the settlement of over 20 active cases.'
>
> The employer wrote - 'Mr. House's "job description" for the period prior to and including Sept. 30, 2000 was the representation of clients in complex litigation. . . .'

Id. (emphasis added) [AUL 000224].

Such a determination would have been wholly unnecessary had the Policy term "regular occupation" been uniformly narrowly construed so as not to provide specialty coverage.

The plaintiff's Policy is an "occupational disability policy," as opposed to a "general disability policy." The latter type of disability coverage defines disability in terms of the insured's inability to engage in *any* gainful occupation. *See* 10 *Couch on Insurance 3d* § 146:3. The former (*i.e.*, an occupational disability policy/own occupation), requires only that the insured be unable to perform the substantial and material duties of his or her particular occupation in order to be considered "totally disabled." *See id.* House purchased a type of coverage that protected him against the risk that an accident or sickness would prevent him from working in his regular occupation (*i.e.*, "own occupation" coverage).[34]

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[34] Although AUL now attempts to distinguish the scope of disability coverage provided by House's former policy with Provident as providing a more generous form of specialty coverage, AUL's claims examiner discerned no difference in the coverage terms. Pursuant to a comparison of the AUL and Provident terms, Ms. Cross concluded that the Provident in fact appeared to be the lesser plan and reported:

> It appears this claim is payable based on the medical received to date. Since it is a pre-existing condition – and no evidence of insurability was required per the sub agreement – a plan comparison was done to determine which is the lesser plan. **It appears the prior plan is a lesser plan because it does not include COLAB [Cost of Living Adjustment Benefits] or S[ocial] S[ecurity] Incentive, and the M[aximum] B[enefit]**

There is no contractual definition of either the terms "the substantial and material duties" or the term "regular occupation."[35] It is well-settled in the Fifth Circuit that, in construing language of ERISA plans, federal law must follow the doctrine of *contra proferentem,* which directs that when plan terms are ambiguous after applying ordinary principles of contract interpretation, courts construe them strictly in favor the insured.[36] Where the term "regular occupation" is not defined in the Plan, a fiduciary must adopt an appropriate description of the claimant's occupation.[37]

> **D[uration] is to age 65, whereas AUL's MBD is a [10year] RBD and for this claimant the MBD is to age 66 (SSNRA).** *The remaining provisions are essentially the same in both policies.*

Claim Summary of AUL's Claims Examiner Linda Cross dated February 23, 2001 (bolding in original and italic emphasis supplied) [AUL 000317].

[35] *See* AUL Policy, Section 2 - Definitions [AUL 000389-396].

[36] *See Fallo v. Piccadilly Cafeterias, Inc.*, 141 F.3d 580, 584 (5th Cir. 1998) (holding ambiguities in ERISA Plan description are construed in favor of the qualified beneficiary); *Wegener v. Standard Insurance Company*, 129 F.3d 814, 818 (5th Cir. 1997); *Todd v. AIG Life insurance Co.*, 47 F.3d 1448, 1451-51 (5th Cir. 1995) (noting that other Circuits also apply the rule in ERISA cases where the construction of insurance contracts is involved); *Ramsey v. Colonial LifeInsurance Co. of America*, 12 F.3d 472, 479 (5th Cir. 1994).

[37] *See Kinstler v. First Reliance Standard Life Insurance Company*, 181 F.3d 243, 252 (2nd Cir. 1999).

Although AUL acquired a thorough description of the House's regular occupation, replete with hourly billings spanning the entire year preceding the onset of his illness, AUL made no effort to adopt an objectively reasonable job description and define House's substantial and material duties based upon the facts provided. Moreover, AUL failed to evaluate House's medical condition against the rigors of the substantial and material duties of his *regular occupation*. Instead, AUL terminated benefits advising House that he was "capable of performing the sedentary occupation of an Attorney as it is normally performed in the national economy."[38]

Louisiana cases expressly reject the requirement that AUL seeks to foist upon the policy at issue – *i.e.*,

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[38] In correspondence dated April 2, 2002, House advised AUL that it had never addressed the question of whether he might be at least "Partially Disabled" under the Policy, noting that he was was earning only 45% of his Indexed Pre-Disability Earnings. *See* Correspondence dated April 2, 2002 [AUL 000005]. AUL's Vice President of Group Claims responded:

> It is American United Life's continued position that the medical information contained in the file and Mr. House's own claimed level of activity does not support his inability to perform his occupation.

See AUL's Correspondence dated May 7, 2002 [AUL 000001]; *see also* AUL's Correspondence dated February 13, 2002 (advising the original determination of November 20, 2001 was correct) [AUL 000008]; AUL's Original Correspondence Terminating Benefits dated November 20, 2001 ("The determination on your claim is that you are capable of performing the duties of your *regular occupation* full time. You appear to be capable of performing the sedentary occupation of an Attorney as it is normally performed in the national economy.") [AUL 000018].

that in the case of "total disability," all duties of an occupation must be affected by the sickness or injury. In *Laborde v. Employers Life Insurance Co.*, 412 So.2d 1301 (La. 1982), the Louisiana Supreme Court found that the plaintiff could no longer work as a journeyman carpenter, and was therefore disabled under the disputed policy, even though plaintiff continued working as a carpenter inspector doing lighter work throughout the two year benefit period provided by the policy. See *id.* at 1304-05 (holding that the plaintiff was unable to perform the substantial and material part of his job in the customary and usual manner); *see also Kottle v. Provident Life and Accident Ins. Co.*, 775 So.2d 64 (La. App. 2nd Cir. 2000), *cert. denied*, 790 So.2d 635 (La. 2001).

The definition of "total disability" provided by AUL's policy is in harmony with Louisiana's well-established jurisprudential rule that the insured who is unable to perform the "substantial and material duties of his occupation" is entitled to policy benefits. *See Laborde*, 412 So.2d at 1304; and *Johnson v. State Farm Mutual Automobile Ins. Co.*, 342 So.2d 664, 667 (La. 1977). The *Johnson* court noted that the insured's intent to obtain coverage in form of economic protection from loss of employment should not be thwarted by narrow policy definitions for total disability requiring absolute helplessness. *Id.*

In *Stender v. Provident Life and Accident Insurance Company*, 2000 WL 875919 (N.D. Ill.), the court considered an occupational disability policy substantially similar to the disability policy's provisions in the case at bar. The plaintiff in *Stender* performed his occupation as commodities pit scalper

up until the time of disability. In 1993, his career in the pit abruptly ended because he could no longer hear well enough to trade in the pits, and his voice had deteriorated to the point that he could no longer be heard on the trading floor. Based upon these disabling conditions, Stender filed a claim of total disability with his insurer. Stender then started to trade commodities from his home, and he retained the right to use the trading pit at the Commodities Exchange ("CMOE"). The court observed that the entire focus of the case law is on how the claimant earned his "primary living" before his injury. *Id.* at 6. Addressing Provident's specific arguments, the court in *Stender* concluded that: (1) the fact that Stender had listed his occupation as broker/trader on his 1992 income tax return was irrelevant, considering that such a characterization did not in any way define the substantial and material duties of his occupation at the time he became disabled; (2) Stender's concessions that he subsequently traded his own commodities or had access to the screens and information on the trading floor actually supported the fact that he could no longer work in the pit; and (3) the fact that Stender's limitations did not preclude him from trading off the floor of the CMOE sidestepped the fact that the most substantial and material part of his trading at the time he became disabled was shouting the buy and sell prices until a striking price was reached. *Stender*, 2000 WL 875919, at 6-7. The district court observed that, without the ability to shout or hear, Stender could not trade in the pit – *i.e.*, the most substantial function of his occupation. Granting summary judgment in favor the plaintiff, the district court noted that the policy in no way restricted Stender from pursuing other career

options, including earning a living by means of continuing his computer trading. *Id.* at p. 7.

In another decision construing similar policy language, the district court considered a practicing dentist's claim for total disability. See *Shapiro v. Berkshire Life Insurance Company,* 1999 WL 566372 (S. D. N. Y. 1999), *aff'd,* 212 F.3d 121 (2nd Cir. 2000). The plaintiff Dr. Shapiro used his time primarily to perform the functions of a dentist who treated patients. However, he also had an ownership interest in his and other dental practices, and also performed managerial and administrative duties for those dental practices. The court in *Shapiro* held that those functions related to his ownership interest in other practices, and his managerial and administrative duties with respect thereto, did not amount to a dual occupation. *Id.* Affirming the district court's decision, the Second Circuit in *Shapiro* observed:

> It is well-settled in New York that occupational disability policies are designed to indemnify against the loss of capacity to work, not against the loss of income. Recovery will not, therefore, be precluded even if the plaintiff were to earn a larger income from his new occupation.
>
> Although earnings may have some bearing on the question of a policyholder's capacity to work, the appropriate inquiry in this case concerns the net income of the individual, rather than his gross revenue (much less the gross revenue of his business). An individual whose sole occupation had been the practice of

> chair dentistry could suffer total disability without losing a cent of *gross* revenue simply by hiring a substitute dentist to treat his patients. Here, the record evidence shows that Shapiro's *net* income *decreased* following the onset of his disability. This fact tends to support Shapiro's argument that he was, in fact, a dentist.

Shapiro, 212 F.2d at 125 (citations and quotation marks omitted).

3. Abuse of Discretion

The only potential unanticipated cost resulting from a different interpretation of the policy language is that AUL will be required to pay benefits to House, and possibly others, if in fact their particular factual circumstances mirror those presented in this case. The crucial issue in this case is whether AUL's interpretation of the Policy is fair and reasonable. Under the Policy an employee is eligible for long-term disability benefits if that employee meets the definition of "disability," which in this case means that "because of injury or sickness [the insured] cannot perform the material and substantial duties of his regular occupation."

On numerous occasions, House explained, defined and documented the substantial and material duties of his regular occupation as a litigator, which requires intense and stressful involvement in pre-trial discovery depositions with clients, opposing parties, witnesses, and opposing counsel, arbitration proceedings in domestic and international tribunals, and court appearances for the purposes of arguing

motions, prosecuting and defending cases in the state and federal courts. Additionally, Dr. Cook made it clear in his original Attending Physician's Statement to AUL that House was "totally" disabled.[39] On January 24, 2001, Dr. Cook advised AUL: "Mr. House is a patient of mine who suffered an acute myocardial infarction and subsequently suffered angina and required an AC bypass. He has been totally and permanently disabled. . . . Because of his coronary disease, his age, myocardial infarction, he will be permanently disabled."[40] Moreover, AUL concluded that based upon the medical documentation received as of February 23, 2001, House's claim should be paid.[41]

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[39] *See* Attending Physician's Statement dated November 29, 2000 (concluding that House cannot practice litigation, is totally disabled, and further noting that House had (1) a Class 3 physical impairment as defined the *Federal Dictionary of Occupational Titles;* (2) a Class 2 degree of functional capacity as defined by the American Heart Association; and (3) a Class 3 degree of mental/nervous impairment as defined by DSM-III multiaxial classification ("Patient is able to engage in only limited stress situations and engage in only limited interpersonal relationships (moderate limitations)") [AUL 0000181].

[40] Correspondence of Dr. Cook dated January 24, 2001 [AUL 000793]; *see also* Correspondence dated February 7, 2001 ("Cannot practice litigation; Total and permanent disability as set forth in letter of 1-24-01.") [AUL 000729]; Attending Physician's Statement dated July 31, 2001 (same) [AUL 000250]; Correspondence of November 1, 2001 (same)[AUL 00026].

[41] *See* Recommendation of Claims Examiner Linda Cross dated February 23, 2001 [AUL 000317].

Notwithstanding the foregoing, almost two months after terminating the plaintiff's benefits, AUL notified House in November of 2001 of its determination, with the following explanation: "[Y]ou are capable of performing the duties of regular occupation full time. You appear to be capable of performing the sedentary occupation of an Attorney as it is normally performed in the national economy."[42] The language utilized by the defendant in denying plaintiff's benefits bears no relation to the Policy definition of the term "totally disabled." Moreover, AUL's claims analyst admits that the job of a "trial attorney is not a sedentary occupation."[43] Equating these disparate activities reflects a plain lack of objectivity and an abuse of discretion by AUL.[44]

A fair reading of the Policy supports the view that, in order to be considered disabled, House must, because of sickness, be unable to perform "the substantial and material duties" of his regular occupation (*i.e.*, trial attorney). Assuming the undefined policy term "regular occupation" is ambiguous, under Louisiana law it is well-settled that ambiguities in insurance policies are construed against

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[42] Correspondence dated November 20, 2001 [AUL 00018].

[43] E-Mail Correspondence of AUL's Kimberly Campbell dated 4/16/2002 (noting that trial work is "not a sedentary occupation and cannot standardly (*sic*) be done in a 40 hr work week") [AUL 000231].

[44] *See Lain*, 279 F.3d at 346.

the insurer.[45] Moreover, under Louisiana law the definition of "total disability" is liberally construed even where the terms of the policy appear more stringent.[46]

Plaintiff's medical conditions and "total disability" are sufficiently evidenced in AUL's file. House's treating cardiologist Dr. Cook opined that because of the job-related stress of trial practice he was "totally disabled" from his occupation as a trial attorney. There is no countervailing medical opinion.

The discharge summary of Dr. Bethea, the plaintiff's heart surgeon, does not contradict Dr. Cook. Dr. Bethea released House to be followed up by his treating cardiologist. Nothing in Dr. Bethea's discharge summary addresses House's ability return to the rigors of a trial practice or to perform the material and substantial duties of that occupation.[47]

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[45] *See Lain*, 279 F.3d at 345 (Assuming the definition of "total disability" is ambiguous, the Fifth Circuit in a ERISA case looked to state law, noting that under Texas law it is well-settled that ambiguities in insurance are construed against the insurer).

[46] *See Laborde v. Employers Life Insurance*, 412 So.2d 1301, 1304 (La. 1982) (Where "total disability" was defined in the policy as "complete inability to perform every duty pertaining to his occupation," the court construed the provision to mean "the inability to perform substantial and material duties of his occupation in the usual and customary way.").

[47] Dr. Bethea's cryptic note dated 11/21/00 states: "I have told him no heavy lifting *or straining until after the first year. Other than*

Moreover, the plaintiff's medical history corroborates the Dr. Cook's opinion. After his heart attack in 1999, House returned to his full-time occupation as a trial attorney billing in excess of 2100 hours. Return to his stressful work as a trial attorney billing 12 to 14 hour days presaged his emergency four vessel coronary bypass surgery performed on October 4, 2000. Despite the fact that AUL determined that an IME or second opinion was necessary,[48] the company chose not to schedule a consult.

Like Mr. House, the plaintiff in *Hoover v. Provident Live and Accident Insurance Company,* 290 F.3d 801 (6th Cir. 2002) underwent coronary artery bypass surgery. As a result of this medical procedure, she was initially able to return to her job as a psychologist on a part-time basis. Hoover's physician opined that her

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that, he can return to full activity and return to see me prn." Office Notes of M.C. Bethea (emphasis added) [AUL 000563].

[48] In the report dated July 6, 2001, AUL's Medical Case Manager noted the goal of establishing a second cardiology evaluation of House. Although calls were placed to two physicians' offices, both declined to accept the assignment to complete a second cardiology evaluation. *See* Initial Report [AUL 000254]. Notwithstanding the fact that discussions with a neuropsychologist associate revealed that there were testing devices that could measure the effects of the stress on the psychological well-being of a person and the reaction of a person to stress, no such tests were ever ordered by AUL in House's case. Because "neuropsychological testing information is usually negated by the opinion of the attending cardiologist," AUL opted instead to pursue a cardiology IME with a physician in the area. *Id.* [AUL 000255]. The record is clear AUL never made arrangements for or requested that House submit to a second cardiology evaluation or IME.

chest pain was stress-related, most of which was related to her work. The treating physician made the determination that Hoover was disabled and recommended that she retire from the counseling profession. *Id.* at 804.

Provident's in-house physician reviewed Hoover's medical records and concluded that, because of a normal stress test and ejection fraction, there was no reason why Hoover could not return to her full-time occupation. *Id.* at 805. Hoover submitted to an IME on Provident's suggestion. Provident's in-house counsel reviewed the IME and concluded that there was no objective evidence to support the work restrictions imposed by Hoover's treating physician. Provident terminated disability benefits for the reason that the work restrictions appeared to be preventive measures. Provident denied Hoover's appeal based on a review by a third in-house physician. *Id.* at 806.

The district court reversed Provident's decision, and the Sixth Circuit affirmed on appeal, holding that district court should have given no weight at all to Provident's rulings. Absent a grant of discretionary authority in the policy to determine eligibility for benefits or to construe the terms of the plan, determinations regarding Hoover should have been reviewed *de novo*. The Sixth Circuit held that when only Provident's in-house non-examining physicians disagreed with the treating physicians, the evidence in the administrative record does not support a denial of benefits.

Defendant cites *Brown v. Washington National Insurance Company*, 942 F.Supp. 1078 (E.D. La. 1996),

which is factually inapposite. In *Brown,* Washington National Insurance accepted in theory the differentiation between "trial attorney" and "attorney." The district court denied summary judgment because (1) the parties failed to document the difference, and (2) the insurer disputed the plaintiff's characterization of his regular employment as a trial attorney. Brown, a lead trial attorney for Stone, Pigman law firm, had not litigated since 1990. *Id.* at 1080-81.

In the case at bar, there is no dearth of documentation that House was in fact a trial attorney at the time of the onset of disability. AUL's file is replete numerous references to House as a "trial attorney,"[49] and discussion of the detailed time records submitted by his firm documenting the long hours spent in the heat of courtroom battle and contentious discovery and motions building up to and including trial on the merits. Whether a courtroom battle, the client's deposition, or an argument defending a position on appeal, House described each and every setting to AUL as stressful and fraught with opposition.

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[49] *See* Facsimile Cover Sheet dated 5/16/01 (recommending that AUL's Andrew Eagan require that Mr. House fill out the trial attorney questionnaire) [AUL 000263]; RN Medical Consultant Referral Response dated April 17, 2001 (noting claimant's occupation as "Trial attorney") [AUL 000283]; E-Mail dated April 12, 2002 (stating AUL's file contains documentation from both Mr. House and the employer that he was a trial attorney) [AUL 000228]; RN Medical Consultant Referral Response dated March 22, 2001 (noting claimant's occupation as "Trial attorney") [AUL 000290].

AUL's citation of *Cooper v. Paul Revere Life Insurance Company,* 1997 WL 375884 (E.D. La.) also bears no parallel, there being disputed issues of material issue of fact in that case. In *Cooper,* Judge Duval denied summary judgment because the parties' medical experts differed on whether the risk posed to the plaintiff by job-related stress constitutes a present disability, or, as defendant maintained, a risk of disability in the future which would not entitle the plaintiff to benefits under the policy.

F. Conclusion

Regardless of whether a *de novo* or arbitrary and capricious standard is used, a record this strong, including the uncontroverted opinion of House's treating cardiologist that he is presently disabled from his regular occupation (trial attorney), mandates a ruling in favor the plaintiff. AUL's failure to obtain an IME, despite the urging of its own Medical Case Manager and awareness that an IME was a necessary predicate to the determination of House's current restrictions and limitations, cannot be ignored by the Court. The failure to get an IME was not an oversight.[50] Neither provisions of ERISA nor the lay

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[50] *See* Report of Phone Contact by AUL's Senior Claims Analyst dated June 7, 2001 (noting that (1) "the IME has not been scheduled yet," (2) "we want to add one element to the IME that the consultant be experienced with considering occupational stress", and (3) "we are looking for his physical functional level *along with his ability to handle the stress of his regular occupation*") [AUL 000262]; E-Mail by AUL's Steve Torrence dated April 12, 2002 ("[W]e decided not to do an IME. We contacted two cards [cardiologists] and both refused to do the examination,

opinion of a claims analysts on the import of selective medical test results provide concrete or competent countervailing medical evidence.

In summary, the policy at issue only requires proof that House is unable to perform the substantial and material duties of his regular occupation. The record contains uncontroverted medical evidence supporting his "total disability" claim. Further, there is no evidence in the record that House was capable of resuming his regular occupation as a trial attorney after October 2, 2000, without adverse and objectively demonstrated physical consequences. AUL has not presented any such evidence. Applying the more rigorous *de novo* standard of review as required, the Court can only find "total disability." Nothing in the claims file justifies AUL's decision that a change in circumstances warranted termination of benefits. The only changes that occurred after his bypass surgery were that House reassigned his caseload, resigned from trial practice, and continued his follow-up treatments with Dr. Cook, along with prescription drug therapy and cardiac rehabilitation therapy. There is no evidence that the plaintiff recovered the ability to perform his pre-disability occupation which consisted almost exclusively of trial practice. Indeed, the record reflects that House continues (1) to take heart medications as prescribed and modified from time to time by Dr. Cook, (2) to strictly adhere to the course of follow-up treatment and care for his heart condition,

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(reasons unknown) and by that time the medical indicated he was ok from a cardiac so we didn't think it would be of value.") [AUL 0000224].

(3) to follow a regimen for cardiac rehabilitation which includes strenuous physical exercise, and (4) to heed the proscription of his treating cardiologist placing his lucrative but overly stressful (and thus, life threatening) pre-disability occupation as a trial attorney off limits.

Accordingly, partial summary judgment in favor of the plaintiff on the issue of "total disability" is warranted.

II. AUL's Cross-Motion for Summary Judgment

A. Undisputed Facts Relative to the Application of ERISA

There were no "employees" of the House firm insured either under the policy which afforded Class 1 LTD coverage to House or the purported "Group" Policy detailing Class 1 LTD coverage. More specifically, the AUL policy issued and delivered to House, as Insured,[51] as well as the Class 1 LTD Group Policy, which AUL argues is included within "the Plan" coverage,[52] by their terms apply only to "Eligible Full-Time Partners."[53] It is further uncontroverted that:

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[51] *See* Good #2.

[52] *See* AUL's Motion and Order for Leave to File Exhibits and attached Exhibits; and AUL's Class 1 Group Policy [AUL 000384-422].

[53] *See* Certificate Schedule Benefits [AUL000387].

- House paid 100% of his premiums, and that the "Employer," House, Kingsmill & Reiss, LLC, paid 0% his premiums.[54]

- Coverage within the meaning of what is purported to be the House Firm's "ERISA Plan," requires that the "[e]mployer . . . contribute at least 25% of the premium for a covered person's LTD coverage."[55]

- The House firm paid 100% of the premiums for persons covered by Class 2 and Class 3 LTD policies/coverages applicable to all eligible full-time employees and full-time non-Partner attorneys, respectively.

- The Certificate of Insurance issued to House by AUL specifically provides that the calculation of disability benefits would be based upon his Schedule K-1, a schedule for partners.[56]

- Consistent with the fact that the House Firm paid 0% of the plaintiff's premiums for

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[54] *See* Group Life/Long Term Disability Application (stating the name of the "Employer" as "House, Kingsmill & Riess LLC," Federal Tax Identification No. "72-1140481") [AUL000374];

[55] *See* Description of LTD Coverage under Percentage of Employer Contribution [AUL000379].

[56] See AUL000379 (describing classification descriptions and long term disability coverage and denoting K-1 earnings for Class 1, *i.e.*, full-time eligible partners).

LTD coverage, page one of the policy, which is the Certificate of Insurance issued to House, as Insured states: "Group: **Does Not Apply**."[57]

B. Contentions of the Parties

Referring to three separate form policies (AUL 000373-501), AUL's position is that it issued one policy of long term disability benefits for the partners, non-partner attorneys and employees of the House firm in May 2000. AUL contends that House's disability policy is a component of an employee welfare benefit plan under ERISA. Specifically, it argues that where employee benefits are funded by more than one insurance policy, the entire benefit program, including House's disability policy, is governed by ERISA.

House's argument is threefold, to wit: (1) the provisions of ERISA do not cover a trust for the "business and professional" industry, because such a trust, by definition, is made up of employers and employees from innumerable disparate and unrelated industries;[58] (2) ERISA regulations 29 C.F.R. § 2510.3-3 state that an "employee benefit plan" does not include a plan where "employees" are not participants; and (3) the case of *Steiner v. Fortis Benefits Insurance Company*, 2000 WL 877013 (E.D.

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[57] *See* Certificate of Insurance issued to House effective 5/1/2000 (bolding emphasis in original) [Good # 2]

[58] *See MD Physicians & Associates, Inc. v. State Board of Insurance*, 957 F.2d 178 (5th Cir. 1992).

La.) falls far short of supporting AUL's argument, and rather bolsters the plaintiff's contention that Policy falls within the safe harbor provision promulgated by the Department of Labor.[59]

C. Application of ERISA

1. Whether an Employee Welfare Benefit Plan Exists

In order for ERISA to govern plaintiff's claims under the Policy, this Court must decide, as a threshold matter, whether the Policy constitutes an "an employee welfare benefit plan" as that term is defined by ERISA.[60] If governed by ERISA, then state law claims relating to that plan are preempted.[61]

An employee welfare benefit plan is defined as:

> any plan, fund, or program which was . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or

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[59] *See* Plaintiff's Post-Argument Supplemental Brief, at pp. 2-3 (*citing* 29 C.F.R. § 2510.3-1(j)(1)-(4)).

[60] *Meredith v. Time Insurance Co.*, 980 F.2d 352, 353 (5th Cir. 1993) (the inquiry is a question of fact).

[61] 29 U.S.C. § 1144(a) (barring state law claims that (1) address areas of exclusive federal concern such as the right to receive benefits under an ERISA Plan, and (2) directly affect the relationship between traditional ERISA entities).

> hospital care or benefits in the event of sickness, accident, [or] disability. . . .

29 U.S.C. § 1002(1).

2. The Employee Requirement

A plan must, among other things, satisfy the primary elements of an ERISA plan – *i.e.,* "establishment or maintenance by an employer intending to benefit employees."[62] One of the most important aspects is that an ERISA plan benefit *employees.* A plan without employees is not regulated by ERISA.[63] *Meredith v. Time Insurance Co.,* 980 F.2d 352, 356-58 (5th Cir. 1993) (holding that 29 C.F.R. § 2510.3-3(c) prevents application of ERISA to medical insurance policy where plaintiff was sole proprietor and policy covered only the plaintiff and her spouse).

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[62] *Meredith,* 980 F.2d at 355.

[63] 29 C.F.R. § 2510.3-3(b) provides: "(b) *Plans without employees.* For purposes of Title I of the Act and this chapter, the term 'employee benefit plan' shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called 'Keogh' or 'H.R. 10' plan under which only partners or only a sole practitioner are participants covered under the plan will not be covered under title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I. Similarly, partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to title I."

The Department of Labor has excluded sole proprietors and spouses, who jointly own corporations, from the definition of ERISA employees; it has also excluded partners in a partnership from being deemed to be employees with respect to the partnership.[64] Accordingly, for the purpose of determining whether a plan is governed by ERISA, business owners are not counted as employees to satisfy the ERISA requirement that the plan benefit employees.

As the Eleventh Circuit recently explained:

> The gist of ERISA's definitions of employer, employee organization, participant, and beneficiary is that a plan, fund or program covers ERISA participants because of their employee status in an employment relationship, and an employer or employee organization is the person that establishes or maintains the plan, fund, or program. Thus, plans, or programs under which no . . . employees or former employees participate are not employee welfare benefit plans under title I of ERISA.

Slamen v. Paul Revere Life Insurance Co., 166 F.3d 1102, 1104 (11th Cir. 1999) (footnotes and internal quotations omitted). In *Slamen*, an individual who

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[64] 29 C.F.R. § 2510.3-3(c) provides: "(c) *Employees.* For purposes of this section: (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership."

wholly-owned a business participated in an insurance plan funded by his business that covered only himself. *Id.* at 1103-04.The insurance plan was not governed by ERISA. *Id.* at 1105.

The *Slamen* court cited the Fifth Circuit case, *Robertson v. Alexander Grant & Co.*, 798 F.2d 868 (5th Cir. 1996), *cert. denied,*479 U.S. 1089 (1987). In *Robertson,* the Fifth Circuit held that two plans, one of which covered owners of a business and the other covering employees, were two separate plans for the purposes of ERISA. *Id.* at 871. The Fifth Circuit rejected the argument that the two plans were nearly identical, and explained:

> Robertson's argument, however, misses the point. His argument ignores the fact that the plans are two separate plans. The plan covering the partners does not pay benefits to principals, and the plan covering principals does not pay any benefits to partners. Since the plans are separate, the plan covering the partners covers only partners, and the district court correctly ruled that the plan does not cover employees other than partners.

Id. at 871-72 (finding that the Grant plan covered only partners and affirming the district court's ruling holding ERISA inapplicable to plans covering only partners).

The Fifth Circuit has devised a comprehensive test for determining whether a particular plan qualifies as an employee welfare benefit plan. Under this test, a court must ascertain "whether a plan: (1) exists; (2)

falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an ERISA employee benefit plan-establishment or maintenance by an employer intending to benefit employees."[65] At the outset the court must first satisfy itself that there is in fact a plan at all. In determining whether a plan exists, a court must determine from the surrounding circumstances that a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.[66]

In this case, House contends that the disability policy he purchased from AUL in May of 2000 is not an ERISA plan because he was a partner and the only named insured under the policy. House points out that the Group LTD Class 1 policy similarly excludes employees from coverage, because only full-time partners are eligible to enroll in the Group LTD Class 1 policy or plan. Moreover, that policy offers materially different benefits than the employees' Group LTD policy or plan.

As to whether at least one employee was a participant, the Policy's eligibility requirements exclude employees from coverage, *i.e.*, only full-time partners are eligible for membership in the Class 1 LTD Group Policy or plan. Although the employer was

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[65] *Meredith*, 980 F.2d at 354.

[66] *See Hansen v. Continental Insurance Co.*, 940 F.2d 971, 976 (5th Cir. 1991) ("Whether a particular set of insurance arrangements constitute[s] an 'employee welfare benefit plan' is a question of fact.").

required to contribute at least 25% of the premium for a *covered person* under the Group LTD coverage, by design the House, Kingsmill firm paid 0% of the partner's LTD premiums in the event a partner opted to purchase a Class 1 LTD Policy. Moreover, because House paid 100% of his own premiums for the Policy, he was not covered by the Class 1 LTD Group Policy or Plan.[67] Where "all of the benefits" of a given policy/plan "flow to the owner," and in this case all benefits arguably by definition can only flow to owners of the House firm (*i.e.*, full-time partners), ERISA does not apply. *See Slamen*, 166 F.3d at 1106; *Robertson*, 798 F.2d at 871-72.[68]

In its supplemental memorandum, AUL cites *Steiner v. Fortis Benefit Insurance Company*, 2000 WL 877013 (E.D. La.) for the propositions that: (1) a formal document designated as the "Plan" is not required in order to establish that an ERISA plan exists; and (2) the purchase of multiple policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established.[69] However, the facts of *Steiner* are distinguishable from those before the Court. In *Steiner*, the plaintiff was a shareholder

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[67] *See* Supplemental Exhibits in Support of Application of ERISA, "BENEFITS DESIRED FOR LTD COVERAGE," at para. 2 (requiring that the "[e]mployer (*i.e.*, the House firm) pay at least 25% of the premium for a *covered person's* LTD coverage.").

[68] *See also* 29 C.F.R. § 2510.3-3(c)(2) (excluding all policies covering only partners, regardless of the numbers, and thus the degree of any given partner's influence over ERISA-related decisions).

[69] *See* Defendant's Post-Hearing Brief, at p. 3.

in the law firm of Hoffman, Sutterfield, Ensenat and Bankston. The firm applied to Fortis Benefits Insurance Company for group long-term benefits applicable to all employees, who were to be covered immediately. Initially, the Fortis policy was non-contributory, with the entire premium for the group policy paid by the firm. Thereafter, the Fortis policy was converted to a contributory policy retroactive to the date of inception. Under the policy there were two eligible classes of persons covered. Most notably, plaintiff Steiner was a member of Class I, which included "[e]ach Active, full-time Director, Associate, and Administration employee of the policyholder. In other words, the policy considered by the *Steiner* court unquestionably covered *employees* of the Hoffman, Sutterfield law firm. Hence, the court concluded that "the purchase of long term disability insurance through a group policy for its employees is a 'plan,' *assuming Hoffman Sutterfield actually purchased the benefits through its own funds for its employees.*" *Id.* at 3 (emphasis added). Because there was insufficient information in the record regarding whether Steiner's employer paid any portion of her premium and its role thereafter, the district court denied Fortis' motion for summary judgment. The court explained:

> There is simply insufficient information in the record to determine whether the plan in question falls within the safe harbor provision of the Department of Labor and thus is outside

> of the scope of ERISA.[70] If ERISA does not apply, then Louisiana law is applicable to the provisions of the policy and will determine whether the plaintiff will succeed on her claim. Because there are material issues of fact not established by the mover in determining whether the plan falls within the safe harbor provision, and because the defendant's motion is based upon the application of ERISA . . ., the motion must be denied.

Steiner, 2000 WL 877013, *5.

House's Policy provides that only full-time partners are eligible for membership, as does the the Class 1 LTD Group Policy. Moreover, partners pay 100% of their premiums for such coverage. House submits that he paid 100% of his premiums and AUL does not argue otherwise. Disability insurance was clearly intended, however, the intended beneficiaries were exclusively full-time partners, with premiums paid 100% by the partner opting for such coverage.

3. Safe Harbor Provision

AUL has failed to meet its burden with respect to the first prong of the inquiry – *i.e.*, whether a plan exists at all. Nevertheless, the Court turns to the

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[70] "Merely stating that the policy is established under ERISA does not meet the requirements of the jurisprudence in creating a Plan governed by ERISA or in defeating the Department of Labor safe harbor provisions so as to be exempted from ERISA regulation." *Steiner*, 2000 WL 877013, *5 n. 1.

second inquiry. If a plan meets all four criteria contained in 29 C.F.R. § 2510.3-1(j)(1)-(4), it falls within the safe-harbor provision promulgated by the Department of Labor and is exempt from ERISA's coverage.[71] A plan falls within the exemption and is not an ERISA plan if it satisfies all four of the following criteria: (1) the employer does not contribute to the plan; (2) participation is voluntary; (3) the employer's role is limited to collecting premiums and remitting them to the insurer; and (4) the employer receives no profit from the plan.[72]

The relevant policy or plan for purpose of this Court's determination is the policy issued to House or the House firm's Class 1 LTD Group Policy. The House firm paid no premiums and House's participation was voluntary. Each partner was required to pay 100% of their own premiums and there is no countervailing evidence. AUL's argument that the House, Kingsmill firm paid 100% of the premiums for employees' Class 2 and 3 Group LTD policies misses the point. The relevant policy or plan in this case was House's policy or the Class 1 Group LTD policy which covered only full-time partners. Moreover, only full-time employees were eligible for coverage under the Class 3 LTD policy, and only full-time non-partner attorneys were eligible for coverage under the Class 2 LTD policy.

As to whether the firm merely collected premiums and remitted them to the insurer, AUL directs this

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[71] *See Meredith*, 980 F.2d at 255.

[72] *See* 29 C.F.R. § 2510.3(j)(1)-(4).

Court's attention to the Subscription Agreement. However, it is far from clear on this record whether the provisions of the subscription agreement and the employer's actual role in fact coincide. Although AUL argues that the House, Kingsmill firm was required to take an active role in determining eligibility for benefits, the defendant cites no evidence suggesting that the firm took an active role in either determining eligibility or in serving as a plan or claims administrator or conduit with respect to the Policy. The House, Kingsmill firm does not appear to have provided House with a summary plan description. On this record, a trier of fact could conclude that the House, Kingsmill firm did nothing more than ministerial tasks and passed along House's premium payments to AUL, essentially in the form of a payroll deduction. The Court cannot find, as a matter of law, that the House, Kingsmill Law Firm endorsed or chose the Policy at issue, when it contributed no part of the premium and participation in the partner's policy was voluntary in all respects. Finally, there is no evidence in the summary judgment record from which to conclude that the House, Kingsmill firm profited from the issuance of the disability policy to House. The record evidence demonstrates that all premiums were remitted to AUL.

The district court's opinion in *Bourg v. NN Investor's Life Insurance Co.*, 1991 WL 211568 (E.D. La.) is not persuasive, due to salient factual distinctions. In *Bourg*, the policy application and the premium schedule showed that the insurance policy was obtained by Bourg Realty Partners for two non-partner employees, who were not family members. Bourg Realty Partners also admittedly purchased a

medical insurance policy for partners and employees *via* the Mass Market Trust. Additionally, it paid 100% of the insurance premiums, and thus was not exempt from the safe harbor provision of 29 C.F.R. § 2510.3-1(j). *Bourg,* 1991 WL 211568, *2 (E.D. La.).

The case at bar is more closely analogous to *St. Martin v. Provident Life & Accident,* 1993 WL 262708 (E.D. La.). In the *St. Martin* case, Guardian asserted that the St. Martin firm established an ERISA plan and that benefits under the plan are funded through the purchase of several insurance policies, including the purchase of a professional disability policy for Michael St. Martin. *Id.* at *1. Citing *Robertson, supra,* the court held that St. Martin's professional disability policy was not governed by ERISA. The court rejected Guardian's contention that because St. Martin had indicated on his application for the disability policy that the firm would pay 100% of the policy premiums, the disability policy was a component of the firm's ERISA plan. The court noted that the evidence showed the contrary, *i.e.,* that the premiums were taxed as income to St. Martin in 1990 and 1991. Relying on *Robertson, supra,* the court concluded that St. Martin's disability policy, which provides benefits solely to a partner, is not part of the firm's ERISA plan. *Id.* at *2.

AUL suggests that this Court may ignore the fact that only full-time partners were eligible to be *covered persons* under the Policy and the fact that the House, Kingmill law firm paid 0% of the premiums for House's or any other Class I LTD insurance policy. AUL cites *Hollis v. Provident Life and Accident Insurance Company,* 259 F.3d 410, 416 (5th Cir. 2001) and *McNeil v. Time Insurance Company,* 205 F.3d 179, 190 (5th Cir.

2000) as authority for its argument that whether House was an employee, or an owner, or taxed like a partner is wholly irrelevant to the issues before the Court. However, *Hollis* and *McNeil, supra,* are factually inapposite.

In the *Hollis* case, there was no dispute that Hollis, participated in Graduate Supply House, Inc.'s program, which provided life, medical and disability insurance for its employees. By all accounts, Hollis was an independent contractor but was treated as an employee. Indeed, Graduate Supply paid $600.00 per year, or $50.00 per month, of Hollis' disability premiums on his Provident LTD policy in the same fashion and denomination it paid premiums for its bona fide employee salesmen, who purchased disability insurance pursuant to the company's plan or program, albeit from a different company, Lincoln Life. The district court denied Provident's Motion for Summary Judgment, and the case was tried to a jury, which returned a verdict awarding policy benefits and bad faith damages under Mississippi state law to the plaintiff. *Id.* at 412-14.

On appeal, Provident argued that ERISA governed the plan and that Hollis' state law claims are preempted. Hollis conceded that Graduate Supply established and maintained an ERISA plan. The issue, therefore, was whether Hollis' disability insurance policy with Provident constituted part of Graduate Supply's ERISA plan, which allowed salesmen to choose a disability policy, and Graduate would pay $600 per year in premiums on whatever policy the salesmen chose. At the end of its analysis, the Fifth Circuit concluded that because Hollis was a person

designated by the terms of the plan who could become entitled to benefits thereunder, he was an ERISA beneficiary. The most noteworthy distinctions are that: (1) the existence of an ERISA plan was conceded in *Hollis;* and (2) admittedly Gator Supply paid $600 per year of the Provident policy's annual premium such that the safe harbor provision was inapplicable to the Provident policy. Moreover, because the "employer" paid a portion of Hollis' premium, independent contractor or not, he was unquestionably a *person covered* by Gator Supply's plan, which also extended benefits to salesmen *employees. Hollis,* 259 F.3d at 414-15.

The Fifth Circuit's decision in *McNeil* is also distinguishable in pertinent part. Most notably, a *single* plan existed that covered both Dr. McNeil (a partner) and the secretary Ms. Jana Jay (an employee). *McNeil,* 205 F.3d at 189. Moreover, the *McNeil* court recognized the exception that *a plan with no employees does not constitute an ERISA benefit plan,* to wit:

> It is true that a plan in which the only participants are the owners or partners does not constitute an ERISA benefit plan. *Meredith v. Time Ins. Co.,* 980 F.2d 352, 357-58 (5th Cir. 1993). But that is not the case here, because the plan covered both Dr. McNeil and Ms. Jay. *See Vega v. Nat. Life Ins. Services, Inc.,* 188 F.3d 287, 291 (5th Cir. 1999) (*en banc*) (plan covering owners and employees constituted ERISA plan); Peterson v. American Life & Health Ins. Co., 48 F.3d 404, 408 (9th Cir. 1995) (the involvement of

> at least one employee is sufficient to establish the existence of an ERISA plan).

Id. at 190 n. 17. Finding that "Time's plan does not fall within the ERISA safe harbor," the Fifth Circuit highlighted the fact that this partnership established a *single plan,* and that both Dr. McNeil and the firm's secretary Ms. Jay were members of the same plan. *Id.* at 190. The court explained:

> As the district court noted, the evidence clearly establishes that the partnership contributed to the plan. Though the partnership's contributions were for Ms. Jay, not Dr. McNeil, all documents filed with Time indicated that the two were members of the same plan.

Id.

D. Conclusion

The summary judgment evidence in the instant case establishes that full-time partners were covered or eligible for coverage *solely* under the House Policy.[73] The policy issued to House, as insured, on the policy form available only to full-time partners, provides more generous disability benefits than the Class 3 LTD Group Policy, which afforded coverage to full-time eligible employees of the House firm. House paid 100% of his own premiums for his Class 1 LTD policy. Under the Class 2 and 3 LTD policies, the House, Kingsmill firm paid 100% of premiums.

It is axiomatic that in the context of summary judgment, the Court must construe the evidence in

favor the plaintiff and not against him. On this record, the Court may not conclude, as a matter of law, that the House, Kingsmill Law Firm "established or maintained" an employee welfare benefit plan with the intent to provide disability benefits to House, or that the Class 1 LTD Policy issued to House was a component of a comprehensive *employee* benefit plan.[74] Accordingly, and for all of the above and foregoing reasons,

IT IS ORDERED that the Defendant's Motion for Summary Judgment is DENIED.

IT IS FURTHER ORDERED that the Plaintiff's Motion for Partial Summary Judgment is GRANTED.

New Orleans, Louisiana, this 3d day of December, 2002.

/s/
KURT D. ENGELHARDT
UNITED STATES DISTRICT JUDGE

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[74] See *Slamen v. Paul Revere Life Insurance Co.* 166 F.3d 1102, 1106 (11th Cir. 1999); *Page v. UNUM Life Ins. Co. of Am.*, 2000 WL 748 154 (N.D. Tex); *Hampton v. Provident Life & Accident Ins. Co.*, 1999 WL 1332189, at *3 (E.D. La.) (relying on *Robertson v. Alexander Grant & Co.*, 798 F.2d 868, 870-72 (5th Cir. 1986)); *St. Martin v. Provident Life & Accident Ins. Co.*, 1993 WL 262708 (E.D. La.).

APPENDIX E

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 06-30168

[Filed October 4, 2007]

WALTER RICHARD HOUSE, JR., Plaintiffs-Counter-Defendants-Appellees,	)
v	)
AMERICAN UNITED LIFE INSURANCE COMPANY, Defendant-Appellant-Cross-Appellee.	)

Appeal from the United States District Court for the Eastern District of Louisiana, New Orleans

ON SUGGESTION FOR REHEARING AND REHEARING EN BANC

Before REAVLEY, GARZA, and DENNIS, Circuit Judges.

PER CURIAM:

Treating the suggestion for rehearing en banc as a petition for panel rehearing, it is ordered that the petition for panel rehearing is DENIED. No member of the panel nor Judge in regular active service of this Court having requested that the Court be polled on rehearing en banc (Federal Rules of Appellate Procedure and Local Rule 35), the suggestion for Rehearing En Banc is DENIED.

In his petition, House contends, among other things, that we erred when we concluded that the benefits American United Life insurance Co. was required to pay him for his partial disability terminated in February 2002 when the policy was terminated. *See House v. Am. United Life Ins. Co.*, 499 F.3d 443, 2007 WL 2473310, at *9 (5th Cir. Sept. 4, 2007). House argues that we should have examined his claim under LA. STAT. § 22:215(A)(1)(d), which covers group health insurance policies specifically, instead of examining his claim under § 22:213(B)(7), which covers insurance policies generally. The result is the same, however, under either section because the termination of the insurance policy did not prejudice any benefits House had accrued under the policy. *Compare* LA. STAT. § 22:215(A)(1)(d) (noting that the "modification, amendment, or cancellation" of a group health insurance policy "shall be without prejudice to any claim for benefits accrued" and noting that benefits accrued "shall be as defined and limited by the terms of the policy") *with* § 22:213(B)(7) (noting that the "cancellation" of the policy "shall be without prejudice to any claim for benefits accrued" and noting that benefits accrued "shall be as defined and limited by the terms of the policy"). The only benefit House accrued under the policy was the right to receive

payment for his partial disability until the policy was terminated. Thus, once the policy was terminated in February 2002, by the policy's terms, House was no longer entitled to payment for his partial disability. Accordingly, the termination of the policy did not prejudice any benefit House had accrued.

DENNIS, Circuit Judge, dissenting from the denial of panel rehearing:

I respectfully dissent from the refusal to rehear this case for the reasons assigned in my dissenting opinion.

APPENDIX F

STATUTORY PROVISIONS INVOLVED

28 U.S.C. § 1652. Rules of Decision Act

The laws of the several states, except where the Constitution or treaties of the United States or Acts of Congress otherwise require or provide, shall be regarded as rules of decision in civil actions in the courts of the United States, in cases where they apply.

29 U.S.C. § 1144. ERISA's Savings Clause

(b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

La. Rev. Stat. 22:230. Disability Loss of Income Policies

A. An individual or group disability loss of income policy to provide loss of income protection against total disability may be issued in this state consistent with the definitions and provisions of this Section.

B. Total disability may be defined in relation to the inability of the person to perform duties but shall not be based solely upon an individual's inability to:

(1) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation"; or

(2) Engage in any training or rehabilitation program.

C. A general definition of total disability in such a policy shall not be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is, or becomes, qualified by reason of education, training, or experience and which provides him with substantially the same earning capacity as his former earning capacity prior to the start of the disability.

D. An insurer may specify the requirement of the complete inability of the individual to perform all of the substantial and material duties of his regular occupation or words of similar import.

E. An insurer may require care by a physician other than the insured or a member of the insured's family.

La. Rev. Stat. 22:215. Group Health and Accident Insurance[1]

A. Any insurer authorized to write health and accident insurance in this state shall have power to issue policies described in this Section.

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[1] Health and accident insurance includes insurance"against disablement . . . by accident . . . or . . . sickness." La. Rev. Stat. 22:6(2)(a).

(1) Group health and accident insurance . . . shall conform to the following requirements:

* * * *

(d) Except as may otherwise be provided in the policy or contract of group health and accident insurance or by R.S. 22:228, the policyholder and the insurer may agree to modify, amend, or cancel the group policy, and such agreement shall be binding upon the employee or member insured under the group policy, provided that the modification, amendment, or cancellation shall be without prejudice to any claim for benefits accrued, or for expenses incurred for services rendered, prior to such modification, amendment, or cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy; however, upon cancellation by the insurer, the insurer shall only be liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice. Any cancellation pursuant to this Paragraph shall also comply with the provisions of R.S. 22:636(F).

* * * *

C. Insurers issuing policies under this Section shall be subject to all the other applicable provisions of this Part and Part VI-C. . . .

La. Rev. Stat. 22:213. Individual Health and Accident Insurance

B. Other provisions (optional). No such policy shall be delivered or issued for delivery containing provisions respecting the matters set forth below

unless such provisions are, in substance, in the following forms, or, at the option of the insurer, in forms which in the written opinion of the commissioner of insurance are not less favorable to the policyholder:

* * * *

(7) Cancellation: The insurer may cancel this policy at any time subject to the provisions of R.S. 22:228. Such cancellation shall be by written notice, delivered to the insured, or mailed to his last address as shown by the records of the insurer, shall refund the pro rata unearned portion of any premium paid, and shall comply with the provisions of R.S. 22:636(F). Such cancellation shall be without prejudice to any claim for benefits accrued or expenses incurred for services rendered prior to cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy. The insured may likewise cancel this policy on the above terms. Upon cancellation by the insurer, however, the insurer shall only be liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice and if the policy of insurance is cancelled for reasons other than failure of the policyholder to pay premiums or failure of the insured to maintain eligibility as provided in the policy. Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to

provide the reasons for cancellation as required by this Paragraph.

29 CFR § 2510.3-3. Employee Benefit Plan

(a) General. This section clarifies the definition in section 3(3) of the term "employee benefit plan" for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.

(b) Plans without employees. For purposes of title I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I. Similarly, partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to title I.

(c) Employees. For purposes of this section:

(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and

(2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

APPENDIX G

EXCERPTS FROM POLICY

American United Life Insurance Company ®
Indianapolis, Indiana 46206-0368
Certifies that it has issued and delivered
a Group Policy numbered AULtimate LTD1E to:

Peoples Bank & Trust Company, Trustee For The
American United Life Group Insurance Trust For
The Business and Professional Service Industry
(Hereinafter called the Group Policyholder)

Insured: **House Jr, Richard W**

05/01/2000

Certificate Number: [House's SS #]

Coverage for Dependents: **Not Included**

Change Effective Date
Member: **05/01/00**
Group: **Does Not Apply**

House, Kingsmill & Riess LLC

shall participate in the coverage as a Participating Unit.

* * * *

This certificate describes the coverage provided in the Group Policy. The Group Policy determines all rights and benefits in this certificate and may be amended, cancelled, or discontinued at any time by agreement between AUL, the Group Policyholder and the Participating Unit without notice to the employee. The Group Policy may be examined at the main office of the Group Policyholder during regular office hours.

* * * *

CERTIFICATE OF INSURANCE
GROUP LONG TERM DISABILITY INSURANCE

* * * *

ELIGIBLE CLASSES

All Eligible Full-Time Partners

* * * *

SECTION 2 - DEFINITIONS

* * * *

PERSONAL INSURANCE means the insurance provided under the policy for an insured Person.

* * * *

TOTAL DISABILITY and TOTALLY DISABLED mean that because of Injury or Sickness the Person cannot perform the material and substantial duties of his regular occupation.

PARTIAL DISABILITY and PARTIALLY DISABLED mean that because of Injury or Sickness the Person, while unable to perform every material and substantial duty of his regular occupation on a full-time basis, is:

1. performing at least one of the material and substantial duties of his regular occupation or another occupation on a part-time or full-time basis; and
2. Is earning less than 80% of his Indexed Pre-Disability Earnings due to that same Injury or Sickness.

* * * *

SECTION 5 TERMINATIONS

* * * *

TERMINATION OF A PARTICIPATING UNIT: Insurance for a Participating Unit ceases on the EARLIEST of the following dates:

1. the date the Participating Unit no longer meets the definition of a Participating Unit, or
2. the date the Participating Unit ceases active business operations or is placed in bankruptcy or receivership; or
3. the date the Participating Unit loses its entity by means of dissolution, merger, or otherwise;
4. the date the Participating Unit is eliminated as a Participating Unit by an amendment or change in the policy;

5. the date ending the Coverage Month for which the last premium payment is made for the Participating Unit's insurance;
6. at the end of a Coverage Month, provided that AUL has give at least 60 days prior written notice to the Participating Unit; or
7. at the end of a Coverage Month, if the Participating Unit has given AUL at least 31 days prior written notice;
8. the date the Participating Unit fails to promptly furnish any information which AUL may reasonably require; or
9. the date the Participating Unit, without good and sufficient cause, fails to perform in good faith its duties pertaining to the policy.

If a Person's insurance is terminated due to the termination of a Participating Unit, the Person's rights under the policy are determined as if the policy had terminated on the date that the Participating Unit's coverage terminated.

* * * *

TERMINATION OF THE POLICY: AUL may terminate the policy at the end of any policy month by giving at least 60 days prior notice to the Group Policyholder.

Termination of the policy, or termination of coverage for a Participating Unit, under any conditions will be without prejudice to any claim originating prior to termination.

* * * *

SECTION 6 - PREMIUM PAYMENT

* * * *

WAIVER OF PREMIUM: Premium payments for a Person are waived only during any period for which benefits are payable for that Person.

* * * *

SECTION 7 - GENERAL POLICY PROVISIONS

ENTIRE CONTRACT: The policy and the applications of the individuals, the Participating Unit, and the Group Policyholder constitute the entire contract. . . .

AMENDMENT AND CHANGES: The policy may be amended by mutual agreement between the Group Policyholder, the Participating Unit and AUL, but without prejudice to any loss incurred prior to the effective date of the amendment. . . .

* * * *

CONFORMITY WITH STATE LAWS: Any provisions of the policy in conflict with the laws of the state in which it is delivered are amended to conform to the minimum requirements of those laws.

* * * *

SECTION 8 - INSURING PROVISIONS

* * * *

The Return to Work Benefit and the Partial Disability Benefit will continue until the earliest of the following:

* * * *

9. the date the policy terminates; or
10. the date the Participating Unit's coverage under the policy terminates.

* * * *

APPENDIX H

EXCERPTS FROM SUBSCRIPTION AGREEMENT

* * * *

BENEFITS DESIRED FOR
LONG TERM DISABILITY COVERAGE

1. Classification Descriptions:

Class 1 [*All full time eligible partners*][1]
Class 2 [*All full time eligible attorneys*]
Class 3 [*All other full time eligible employees*]

2. Percentage of Employer Contribution: [*100 %*] of Employee Premium [*partners pay 100% of their attributable cost*] (Employer is required to contribute at least 25% of the premium for a covered person's LTD coverage)

3. Benefits: (Bolded options are standard benefits.)

Definition of Disability: (1year own occ, 2 year own occ, 3 year own occ, 5 year own occ, or Benefit Duration own occ)

Class 1 [*Benefit Duration own occ*]
Class 2 [*Benefit Duration own occ*]

---

[1] Italicized text in brackets indicates handwritten entries.

Class 3 [*3 year own occ*]

* * * *

Basic Monthly Earning include: (Choose one per class)

Basic Monthly Earnings only Class 2 ✓ Class 3 ✓
Basic Monthly Earnings with
Commissions Only (12, 24, or 36 months)
Bonuses Only (12, 24, or 36 months)
Commissions and Bonuses (12, 24, or 36 months)
W2 Earnings with plan contributions
W2 Earnings without plan contributions
Other earnings definition (describe)→[*K-1 earnings*]
Class 1 ✓

* * * *

APPENDIX I

EXCERPTS FROM SUPPLEMENTAL AFFIDAVIT OF JULIAN H. GOOD, JR.

BEFORE ME, the undersigned Notary Public, personally came and appeared:

JULIAN H. GOOD, JR., a competent adult residing in the Parish of Orleans, State of Louisiana, who being by me first duly sworn, did depose and say:

I.

I am the insurance broker who placed the disability insurance for the partners, other attorneys and employees of House, Kingsmill & Reese, L.L.C.

* * * *

IV.

I first contacted AUL's group representative in Houston, Texas, Kevin Calvert, in September of 1999. At that time, in all subsequent conversations, and at the time the application was signed, Mr. Calvert assured me that the AUL disability insurance would provide specialty occupation coverage in the event the attorney could not perform the duties of his specialty. . . .

* * * *

/s/
Julian Good, Jr., CLU, ChFC, CLTC

SWORN TO AND SUBSCRIBED, before me this 31 day of October, 2002.

/s/
NOTARY PUBLIC